PATIENT REGISTRATION FORM FOR DR _____

Drs need this information to provide the best quality care. This form complies with the RACGP Standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Patient Details

Mr/Mrs/Miss/Ms/Mstr _____ Sex Male / Female / Other _____

First Name _____ Surname _____

Aboriginal or Torres Strait Islander PRONOUN Yes / No Ethnicity _____

Date of Birth _____ Marital Status Single / Married /Divorced/De facto

Medicare Number _____ Reference _____ Expiry _____

Pension / HCC No _____ Expiry _____

Vet Affairs No _____ (Gold Card / White Card)

Street Number & Name _____

Suburb _____ Postcode _____

Home Phone _____ Mobile _____

Work Phone _____ Email Address _____

Occupation Country of Birth _____

Emergency Contact YOU MUST UPDATE OF ANY CHANGE IMMEDIATELY PLEASE

Emergency Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

Next of Kin Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

Online Claiming

If you prefer for Medicare to pay your rebate back into your account, please register your bank account details with Medicare.

IMPORTANT!!! PLEASE READ

The Drs preferred method of contact is SMS but any other methods of contact you have provided them (phone, email, letter) may be used when needed. Do not give us any contact we can't use for you for communication with you for any reason including health promotions.

To opt off all SMS communications, you must inform the receptionist today to OPT OFF ☐

Reason for opting off? _____

For SMS messages it is understood that my details are utilised by the Hotdoc /App and Best Practice for the basis of these practice communications (e.g. appt reminders, checkups due, Drs results messages to you, relevant health promotion info) in accordance with the Privacy Act. We also use disease registers to send reminders (to opt off contact them directly). For our privacy policy please visit Drs websites

I further confirm that my mobile phone is for my private use and is locked and has a unique password for my apps known only to me and messages are safe from others access and view and I will keep practice updated of my details or changes in consent

Patient Name: _____ **Signature:** _____

Date: ____ / ____ / ____

OFFICE USE ONLY

Patient ID: Medicare Card ☐ Drivers Licence ☐ Passport ☐ Other

Entered by _____ Date: _____

PTO ➔

Family History

	Father	Mother	Father's Parents	Mother's Parents	Sibling	Children
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

Other _____

Habit Check

Coffee _____ cups/day Alcohol _____ drinks/day or week

Cigarettes _____ no/day EX SMOKER-no.day for yrs Physical Activity _____

Nutrition Issues _____ Ht _____ Weight _____ BMI_____

Drug Allergies

Medication _____ Reaction_____ Mild/ Moderate/ Severe

Medication _____ Reaction_____ Mild/ Moderate/ Severe

Medication _____ Reaction_____ Mild/ Moderate/ Severe

List all medications, vitamins, herbs, creams, potions, lotions you are taking/using

Current Health Problems

Past Health Problems

IMMUNISATIONS