Medistone
Family Practice

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NEW PATIENT REGISTRATION FORM

We require this information to provide you with the best quality care. This form complies with the RACGP Standards of general practices. 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. Please notify us promptly of any changes in your contact details.

SECTION A: PERSONAL DETAILS

Please write your name as it appears on your Medicare card or passport.

Title | Surname | Given Name

Date of birth(dd/mm/yy) | Gender Male/female/Other

Medicare card No | Ref No | Exp /

Concession (Senior's card, Pension, Health card Card) | Exp date /

DVA card number (if applicable) | Gold / White

Home address | Suburb | Post code

Postal address | Suburb | Post code

Mobile Number

Work Number

Landline

Email

Emergency contact details

Name

Relationship to you

Mobile Number

Work number

Land line

Next of Kin details

Name

Relationship to you

Mobile Number

Work Number

Land line

SECTION B: CULTURAL IDENTITY

Knowing your cultural background can help us provide health care that meets your individual needs.

Are you of Aboriginal or Torres strait island origin?

No ☐ Yes, Aboriginal ☐ Yes, Torres strait Islander ☐ Both ATSI ☐

Other cultural background e.g. Mediterranean, Asian, African)

Country of birth

SECTION C: HEALTH INFORMATION

(ALLERGIES AND MEDICATIONS ,SOCIAL HISTORY)

Do you have any allergies No ☐ Yes ☐ (please provide details below)

List regular medication and doses and complementary medicines and doses (please attach list If medication Is extensive)

1.

2.

3.

4.

5.

6.

7.

Medical history -Do you have or have you had a history of the following? Please circle.

- Surgery
- Asthma
- Diabetes
- Hypertension
- Chronic illness

Family history- Do any of your family members have any of the following? Please circle

- Heart disease
- Asthma
- Diabetes
- Hypertension
- Cancer- Type
- Other significant health problems- please provide details.

Social history

Do you smoke? If yes, how many sticks a day? _____

Year started? _____

Do you drink Alcohol? If yes, how many standard drinks per day? _____

how many days a week? _____

SECTION E: CONSENT

At all times we ensure that your details are treated with utmost confidentiality. Your medical records are very important, and we take all necessary steps to ensure they remain confidential.

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email , telephone or SMS for procedures such as vaccination, pap tests and other health reviews

I consent to being contacted with reminders to help me maintain my health. Yes ☐ **No** ☐

Our Practice also sends information to the Australian childhood immunisation register and pap smear Register. These registers also send reminders which can be helpful if you move.

I consent to information being sent to government reminder services. Yes ☐ **No** ☐

Do you consent for your medical history to be uploaded to my health records? Yes ☐ **No** ☐

PATIENT NAME_____

SIGNATURE _____

DATE _____