



Patient Registration form

Surname:	Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Dr <input type="checkbox"/> Miss <input type="checkbox"/> Ms
First Name:	Preferred Name:
DOB:	
Residential Address:	
Suburb:	Postcode:
Mobile:	Home: Work:
Email Address:	

Country of Birth:	Preferred Language:
Do you Identify as: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither	
If YES (ATSI) are you registered for the "Close the Gap" Program: <input type="checkbox"/> YES <input type="checkbox"/> NO	

Medicare Card Number:	Ref:	Expiry:
Pension Card Number:		Expiry:
Healthcare Card Number:		Expiry:
Dept of Veteran Affairs Card Number:		Expiry:

Occupation:					
Relationship Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> De Facto	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widow

Next of Kin:	Relationship:
Phone Number:	
Emergency Contact:	Relationship:
Phone Number:	

I give permission for my Health Record summaries to be uploaded to the National My Health System.

I hereby give express permission to Helensvale Plaza Medical Centre staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf. I acknowledge that I am wholly responsible to arrange any further appointments to discuss test results conducted by my Doctor always.

I give permission to be notified by letter, phone, email or text message for all Routine Recalls and Reminders.

I give consent to access the Pap Smear Register. - *If required.*

HIC Online, For Eligible Bulk Bill Patients

I hereby authorise Helensvale Plaza Medical Centre to process my claim through Medicare Australia

Signed _____ **Dated** _____

Please tick if Parent Guardian

Please TURN OVER to Complete New Patient Medical History Form

New Patient Medical History Form

All information is kept private and confidential and will help our doctors to give you a better long-term treatment plan for your health requirements.

Allergies;

Are you allergic to any medication or materials? **i.e.: Penicillin, Latex?** YES NO

If **YES** what are you allergic to?

Medication;

Are you taking any medication? *(including over the counter medication, vitamins and minerals)*

YES NO

If **YES** what are you taking?

Social History;

Tobacco use: YES NO _____ Day/Week I Quit Smoking _____

Alcohol use: YES NO Days per Week _____ Standard drinks per day _____

Your Health and Family History;

Your History; – Do you have, or have you had a history of:

Asthma Diabetes (Type 1 /Type 2) Hypertension Chronic Illness Depression/anxiety

Thyroid Disease Indigestion or Reflux Stroke Arthritis or Back pain Other **NIL**

Please Give Details:

Your Family History;

Mother: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Breast Cancer **NIL**

Father: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression **NIL**

Please Give Details:

FEMALES - When did you last have;

Pap Smear - Date: _____ Not sure Never

Breast Screen - Date: _____ Not sure Never

Are you Pregnant? YES NO

If **YES** when are you due: _____

Is there anything else you would like to tell us about your general health?

Admin Internal use. Keyed into BP Medicare checked Initials _____ Scanned into BP initials _____ DR Initials _____