North Epping Family Practice – New Patient Registration Form

Section A: Personal Details

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Master ☐ Mr

Surname:_____Given Name:_____

Date of birth: _____Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Medicare Number:_____ Reference Number:_____ Expiry Date:_____

(10 digits on top line of Medicare Card) *(Number you are on the card)* *(bottom right hand corner)*

Pension/ Heath Care Card/ Veterans Affairs No**:** _____

Type of Veterans Affairs card**:** _____Expiry Date**:** _____

Address: _____

Suburb:_____State :_____Postcode: _____

Email:_____

Occupation: _____Work Phone: _____

Mobile Phone: _____ Home Phone: _____

Emergency Contact Details

Contact Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____

Next of Kin

☐ As Above

Contact Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____

Section B: Cultural/Social Background & Family History

Knowing your cultural background can help us provide healthcare first meets your individual needs

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Other cultural background (eg. Mediterranean, Asian, Africa) _____Country of birth _____

Is English your first language? Yes ☐ No ☐ Please specify language _____

Are you a smoker? Former Smoker ☐ No ☐ Yes ☐ how many a day? _____

Are you a drinker? Yes ☐ _____ Daily/Weekly/Monthly No ☐

Do you have any family histories? NO ☐ Yes ☐ Please specify_____

Section C: Allergies and medicines

List allergies and intolerances to medications	described your reaction

List regular medications and doses and complete

Please turn over

Section D: Consent

Our practice uses a reminder system to maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap smear 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 Department of Human Services' Australian Childhood Immunisation Register, Pap Smear Register and My Health Record system.

I consent to being contacted with reminders to help me maintain my health

Yes ☐ No ☐

Signature of Patient: _____Date: _____

Section E: Transfer of health information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact or information or Medicare details change.