**North Epping Family Practice – New Patient Registration Form**

**Section A: Personal Details**

Title: Miss Ms Mrs Mr Master Gender: Female Male

Given Name: Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_

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)*

Centrelink Concession card no. **: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Expiry Date**: \_\_\_\_\_\_\_\_\_\_\_**

Address:

Suburb: State: Postcode:

Mobile Phone: Email:

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: Occupation:

Emergency Contact Details

Contact Name: Relationship: Mobile:

Next of Kin As Above

Contact Name: Relationship: 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  ATSI 

Ethnicity \_\_\_\_\_\_\_\_ Country of birth \_\_\_\_\_\_\_\_\_\_\_\_\_

Is English your first language? Yes  No  Please specify language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a drinker? No  Yes  \_\_\_\_\_\_\_ standard drinks daily/weekly/monthly

Are you a smoker? No  Yes  \_\_\_\_\_\_ cigarettes daily Former smoker 

Do you have any family histories? No  Yes  Please specify (eg father diabetes )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section C: Allergies and medicines** No allergies known

List allergies and intolerances to medications Reaction

|  |  |
| --- | --- |
|  |  |
|  |  |

List regular medications and doses

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 immunisations and allergies being sent to Department of Human Services’ Australian Childhood Immunisation Register and My Health Record system - Yes No

**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.