NEW PATIENT REGISTRATION FORM

☐ Cameron Park Medical Practice ☐ Wallsend Medical Practice

☐ Clarence Town Medical Centre ☐ Paterson Medical Practice

Miss ☐ Ms ☐ Mrs☐ Mstr ☐ Mr☐ Dr☐ **First Name:**_____

Middle Name:_____ **Surname:**_____

Date of Birth: _____ **Country of Birth:** _____

Medicare Number : _____ **Ref No:**_____ **Expiry Date:**_____

DVA Number:(Dept.Veteran Affairs) _____**Expiry Date:**

Pension/Health Care Card (Please circle) No:_____ **Expiry Date:**

Private Health Insurance Fund:_____ **Member Number:**_____ **Expiry** _____

Residential Address:_____

Postal Address :(If Applicable)_____

Home Phone:_____ **Work Phone:** _____ **Mobile Phone:** _____

Email Address:_____

Next of Kin:
Name:_____

Address:_____

_____

Phone No:_____

Relationship To Patient:_____

Emergency Contact:
Name:_____

Address:_____

_____

Phone No:_____

Relationship To Patient:_____

Do you identify as being: **Australian Non-Indigenous** ☐ **Cultural/ Religious Background** _____

Aboriginal Origin ☐

Torres Strait Islander ☐

Other (Specify) ☐_____

Health Information Collection and Use Consent:

We require your consent to collect personal information about you and to use the information you provide in the following ways:-

- **Administrative**
- **Billing**
- **Disclosure to others involved in your healthcare including treating doctors and specialist outside this medical practice**
- **Other doctors within this practice**
- **De-identified for research and quality assurance activities**
- **To comply with any legislative or regulatory requirements e.g. notifiable diseases**
- **To use MBS Online Checker before each appointment to allow us to offer opportunistic care by checking eligibility for Health assessments, chronic disease management and mental health item numbers.**
- **For reminder letters which may be sent to you regarding your health.**

I consent to the handling of my information by the practice for the purposes set out above:-

Signature_____**Date** _____

PATIENT NAME: _____

DO YOU SMOKE? –YES ☐ NO ☐ EX-SMOKER ☐

ALCOHOL -DAYS PER WEEK: _____ **STANDARD DRINKS PER DAY:** _____

ALLERGIES/ADVERSE DRUG REACTIONS: Yes (please list below and reaction) ☐ Nil known

---

MEDICATIONS -Please list your current medications and/or recent surgeries

_____

_____

Marital Status (Please Circle) Single / Married / Widowed / Separated / Divorced / Defacto

Occupation:_____

DO YOU or HAVE YOU EVER, SUFFERED FROM ANY OF THE FOLLOWING– PLEASE TICK AS REQUIRED

YOUR PAST HEALTH HISTORY	FAMILY PAST HEALTH HISTORY (Mother and Father)			
DIABETES	**DIABETES**	Mother/Father	Unknown	NOT KNOWN TO YOU
HYPERTENSION	**HYPERTENSION**	Mother/Father	Unknown	NOT KNOWN TO YOU
STROKE	**STROKE**	Mother/Father	Unknown	NOT KNOWN TO YOU
HEART DISEASE	**HEART DISEASE**	Mother/Father	Unknown	NOT KNOWN TO YOU
CANCER	**CANCER**	Mother/Father	Unknown	NOT KNOWN TO YOU
ASTHMA	**ASTHMA**	Mother/Father	Unknown	NOT KNOWN TO YOU
COPD / EMPHYSEMA	**COPD / EMPHYSEMA**	Mother/Father	Unknown	NOT KNOWN TO YOU
OSTEOPOROSIS	**OSTEOPOROSIS**	Mother/Father	Unknown	NOT KNOWN TO YOU
KIDNEY DISEASE	**KIDNEY DISEASE**	Mother/Father	Unknown	NOT KNOWN TO YOU
DEPRESSION/MENTAL HEALTH	**DEPRESSION/MENTAL HEALTH**	Mother/Father	Unknown	NOT KNOWN TO YOU
ANY OTHER SIGNIFICANT	**ANY OTHER SIGNIFICANT**	Mother/Father	Unknown	NOT KNOWN TO YOU

Reminder System: This practice takes a preventative approach to your health. You may receive phone calls, letters or be reminded at your next visit of on-going follow-up for preventative care as well as SMS appointment reminders. If you do not wish to be part of this system, please tick the box, however we strongly recommend this. ☐

Thank you for taking the time to complete this form.

Please return part 1 of this form to Reception and take part 2 in with you to give to your doctor.

Signature……