



NEW PATIENT REGISTRATION FORM

Admin to complete
Patient details added to file
Date/Initial: _____

Clinical team to complete
Patient details updated in MD
Date/Initial: _____

The information we request assists us in providing you with the highest level of care, disclosure to others involved in your health care, administrative & billing purposes, including compliance with Medicare and Health Insurance Commission requirements. This form complies with the RACGP *Standards for general practices (5th edition)*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with your GP.

Title: Mr Mrs Ms Miss Master Other

First Name: _____ Middle Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: ___/___/___ Gender: _____

Marital Status: Single Married De facto Separated Divorced Widowed

Home Address: _____ Postcode: _____

Postal Address: _____ Postcode: _____
(if different to home address)

Email Address: _____

Telephone Number: _____ Work: _____ Mobile: _____

Consent to SMS reminder and recalls: Yes No Consent for My Health Record upload: Yes No

Medicare card number: _____ IRN: _____ Expiry: ___/___/___

Pension, HCC, or Veterans Affairs Number (if applicable): _____ Expiry: ___/___/___

Next of Kin

Name: _____ Relationship to you: _____

Telephone Number: _____ Mobile Number: _____

Who can we contact in an emergency? (if different to Next of Kin)

Name: _____ Relationship to you: _____

Telephone Number: _____ Mobile Number: _____

Australia is a genuinely multicultural country. The following questions would help us tailor appropriate care, assist with health initiatives and encourage understanding and appreciation between people from different backgrounds.

Are you Aboriginal or Torres Strait Islander descent? Aboriginal Torres Strait Islander Neither

Country of Birth: _____ Ethnicity: _____ Year of Arrival in Australia: _____

Do you require an interpreter? Yes No If so, what language? _____

To whom should the account be addressed if the patient is a child:

Name: _____ DOB: ___/___/___ Phone: _____

Home Address: _____ Postcode: _____

Email Address: _____

Allergies/Adverse Reactions/Warnings:

Do you have any allergies or are you sensitive to medications or dressings? Yes No

Medication, Dressing or substance	Reaction (eg: rash, shortness of breath, wheeze, anaphylaxis)

Smoking History

Smoker Ex-Smoker Never Smoked
 Frequency Daily Less than weekly Weekly
 Number of cigarettes: ____
 Year Commenced: ____
 Last quit attempt: ____ Unknown

Alcohol History

Do you drink alcohol? Yes No Never
 How often do you drink alcohol?
 Month or less 2-4x/month
 2-3x/week 4 or more/week
 How many standard drinks with alcohol do you have per day?
 1 or 2 3 or 4 5 or 6
 7 to 9 10 or more
 How often do you have 6 or more drinks?
 Never Weekly Monthly
 Less than monthly Daily
 Are you concerned about your drinking?
 Yes No Don't know

Current/Past Medical History:

Diabetes _____
 Cancer _____
 Heart Disease _____
 Asthma _____
 Other Conditions _____

Family History: Have any member of your family been diagnosed with or suffered from the above list?

Social/Family History

Who lives at home with you?

Health Check dates:

Last cervical screening test date: _____
 Breast check: _____
 Mammogram: _____
 Prostate (PSA) check: _____
 Bone Mineral Density (BMD) Scan: _____

Medication List (including over-the-counter)

Name	Reason

Immunisations- Please tick routine immunisations received

Birth 6 weeks/2months 4 months
 6 months 12 months 18 months
 4 years Year 7 school Vaccines
 Year 10 school vaccines
 Others: _____

Privacy Consent

I have read the information above and understand the reasons my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but failure to do so might compromise the quality of health care and treatment I receive.

I am aware of my right to access information collected about me, except in circumstance where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set above, subject to any limitations on access or disclosure that I notify this practice in writing.

Practice Use of AI Scribe

Our practice uses AI scribe which allows your doctor to focus more on you and less on computer documentation. I consent to the use of AI scribe during my medical encounters/appointments Yes No

Full Name:	Date:
Signature of Patient or Parent/Guardian:	