Glossodia MEDICAL PRACTICE

02 4576 7499
3/162 Goldenvalley Drive,
Glossodia NSW, 2756

PATIENT REGISTRATION FORM

Title: ❒Mr ❒Mrs ❒Ms ❒Other: __________

Surname: ______________________________

First name: ______________________________
(On Medicare card)

Preferred name: ______________________________

Date of birth: ______________________________

Gender: ❒Male ❒Female

Country of birth: ______________________________

PARENT DETAILS
(If registering a child)

First name: ____________________

Surname: ____________________

Date of birth: ____________________

Medicare No: ____________________

Expiry Date: ____________________

Home address: ______________________________

Town / Suburb: ______________________________ Postcode: ______________

Telephone: Home: ______________ Work: ______________ Mobile: ______________

Email: ______________________________

Usual Occupation: ______________________________

Health Care Card.: ______________________________ Expiry Date: ______________

Pension Card.: ______________________________ Expiry Date: ______________

Commonwealth Senior Health Card No.: ______________________________ Expiry Date: ______________

Medicare number: ______________________________

Line No *(e.g 1 , 2 , 3)*: ______________________________ Expiry Date: ______________

Veterans' Affairs number and Card Type (gold or white): ______________________________ Expiry Date: ______________

Do you identify yourself as Aboriginal or Torres Strait Islander: Yes / No *(please circle one)*

NEXT OF KIN

Name: ______________________________

Phone: ______________________________

Address: ______________________________

____

Relationship: ______________________________

EMERGENCY CONTACT ❒ Same as Next to Kin

Name: ______________________________

Phone: ______________________________

Address: ______________________________

____

Relationship: ______________________________

PTO

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MEDICAL HISTORY

Past medical history: ____
E.g Asthma, Diabetes - (Conditions / illnesses)
____

List of Past Surgeries and When: ____
(E.g Appendix removed in 2014)
____

Current medications: ____
(Note name / dose / frequency)
____

Allergies/Reactions: ____

Family medical history: ____
E.g Asthma, Diabetes, Heart disease,Cancer
____

Smoker: ❒Yes__________(number per day) ❒No ❒Ex-smoker (Year stopped__________)
Alcohol: ❒Yes __________(How often) ❒No
❒Yes __________(How many)
Height: __________________ Weight: __________________

Are you up to date with the following:

Pap Smear (every 2/5 years)	No/Yes/NA	_MM/YY_	*(Please circle one & provide date)*
Skin Check (every 1 year)	No/Yes	_MM/YY_	*(Please circle one & provide date)*
Bowel Screening (every year if over 50)	No/Yes/NA	_MM/YY_	*(Please circle one & provide date)*
Mammogram (every 2 years if over 50)	No/Yes/NA	_MM/YY_	*(Please circle one & provide date)*
Blood test done in the last 12 months (if over 50)	No/Yes/NA	_MM/YY_	*(Please circle one & provide date)*

______________________________ ____/____/____
Patient's Signature Date

ABOUT YOUR INFORMATION AND OUR PRACTICE (USE OF HEALTH DATA FOR RECALL REMINDER SYSTEM & QUALITY IMPROVEMENT

The personal information you provide during your consultation and subsequent treatment will be collected for the sole purpose of providing high quality healthcare. This practice is committed to protecting your privacy and this information is only disclosed to other members of your treating team where medical necessary. It may however be disclosed to organization where required by law.

This practice uses a recall reminder system & engages in ongoing clinical quality improvement. To do this, access to your de-identified medical information is necessary. This information has no name, date of birth, nor any other identifying features if it is used for clinical audits or medical practice quality assessments. Privacy & confidentiality of your medical record is maintained at all times. The practice uses SMS's for reminder and information purposes.

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