NEW PATIENT REGISTRATION FORM

GROSVENOR ST
GENERAL PRACTICE

PATIENT DETAILS

Title:	**Given Name(s):**	**Surname:**
Date of Birth (dd/mm/yyyy)**:**		**Gender:** Female / Male / Transgender (circle) If other, please specify:
Name of Parent/Guardian *(for patients under the age of 14):*		
Do you identify as Aboriginal and/or Torres Strait Islander? Aboriginal / Torres Strait Islander / Both / Neither / Undisclosed (circle)		**Ethnicity:**
Country of Birth:		**Year of Arrival in Australia** (if born overseas)**:**
Spoken Language:		**Preferred Language** (if not English)**:**
☐ *I require interpreting service in my preferred language during consultation – no additional fee*		
Occupation:	☐ *I am a student*	**Marital Status:**

HEALTH FUND DETAILS

☐ *I do not have a Medicare card*		
Medicare Number:	**Individual Reference Number:**	**Valid to:**
☐ *I have private health insurance / overseas visitor / student health cover*		
Private Health Fund:	**Card Number:**	**Expiry:**

DO YOU HAVE ANY OF THE FOLLOWING?

Pensioner Concession Card	**Card Number:**	**Expiry:**
Health Care Card (HCC)	**Card Number:**	**Expiry:**
Department of Veteran Affairs Card (DVA)	**Card Number:**	**Expiry:**

CONTACT DETAILS

Address:		**Suburb/Town:**
State:	**Postcode:**	**Country** (if outside Australia)**:**
Mobile Phone:		☐ *I would like to receive SMS reminders*
Home Phone:		**Email address:**

NEXT OF KIN DETAILS

☐ *I do not have next of kin / I do not wish to disclose any next of kin details*	
Full Name:	**Relationship to Patient:**
Best Contact Number:	**Alternative Contact Number:**
Is this person registered at this practice? Yes / No / Unsure (circle)	

EMERGENCY CONTACT DETAILS

☐ *Same as next of kin*	
Full Name:	**Relationship to Patient:**
Best Contact Number:	**Alternative Contact Number:**
Is this person registered at this practice? Yes / No / Unsure (circle)	

HOW DID YOU HEAR ABOUT US?

☐ Internet Search Engine (please specify):	☐ Word of Mouth
☐ Social Media (please specify):	☐ Other (please specify):

YOUR CONSENT

This Practice collects information from you for the primary purpose of providing quality healthcare. In keeping with the **Privacy Act 1988** and the **Australian Privacy Principles** we wish to provide you with sufficient information on how your personal information may be used or disclosed.

By signing below, you are consenting to the collection of your personal information and that it may be used or disclosed by the Practice for the following purposes:

- Account processing, including compliance with Medicare
- Quality assurance activities
- Disclosure as required by a court of law for legal related issues
- For the purpose of research and only de-identified information is used
- To comply with any legislative or regulatory requirements
- Administrative records

We aim to protect the privacy and secure storage of your health information. All documents are kept confidential. It is the policy of this practice to maintain security of your health information at all times and to ensure that this information is only available to the authorised members of staff.

You can request a copy of our **Privacy Policy** from reception. This policy includes information about the collection, use and disclosure of your health information.

☐ YES, I would like to register to have a **My Health Record** with this Practice.
☐ YES, I consent for the Practice to send me an email asking me to contact the Practice in the event that the Practice is unable to contact me via phone or mail.

YOUR DECLARATION

I hereby declare that:

- The information I have given in this form is true and correct
- I give my consent for my information to be disclosed or used in the points mentioned above
- I have been given a copy of the **Practice Brochure**
- I have read and understood the **Practice Brochure**

Patient Full Name:	**Signature:**
Parent/Guardian Full Name (if applicable):	
Date:	

NEW PATIENT REGISTRATION FORM

PATIENT HEALTH SUMMARY

GROSVENOR ST
GENERAL PRACTICE

We would be grateful if you could complete this **Patient Health Summary** so that the Doctor understands your physical, psychological and social settings. With this information up to date, more appropriate appointments, treatment and follow up can be negotiated by you and your Doctor to maximise your well-being.

CURRENT MEDICATIONS (prescription & non-prescription)

CURRENT AND PAST MEDICAL CONDITIONS (e.g. high blood pressure, asthma, heart attack)

ALLERGIES AND ADVERSE REACTIONS (medications & non-medications)

FAMILY HISTORY (e.g. high blood pressure, cancer, diabetes)

LIVING ARRANGEMENT (e.g. alone, with parents, with partner)

VACCINATIONS AND IMMUNISATIONS

☐ Completed / up to date	☐ Incomplete / never
Others: (e.g. Gardasil®, Zostavax®, Bexsero®, Meningococcal ACWY, influenza, pneumonia, Hep A)	

TOBACCO USE (please tick)

☐ Never ☐ Undisclosed	☐ Ex-smoker When did you quit? _____	☐ Current smoker Quantity: _____ cigarettes daily / weekly (circle) Duration: _____ years Intention to quit: Yes / No (please circle)

ALCOHOL USE (please circle)

How often do you have a drink containing alcohol?	Never	Monthly / less	2-4 times a month	2-3 times a week	4+ times a week
How many standard drinks of alcohol do you drink on a typical day?	1 – 2	3 – 4	5 – 6	7 – 9	10+
How often do you have more than 6 drinks on one occasion?	Never	Less than montly	Montly	Weekly	Almost daily

YOUR DECLARATION

I hereby declare that all information I have provided above is true and correct.	
Patient Full Name:	**Signature:**
Parent/Guardian Full Name (if applicable):	
Date:	
Treating clinician to sign as sighted:	