OFFICE USE ONLY:

Medicare Card Sighted: Y N
Drivers Licence No:

Staff Initials:

CENTENARY MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Language Spoken:	**Is an Interpreter Required:** ❑ Y ❑N

PATIENT INFORMATION

Patient's last name:	**First**:	**Middle**:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	**Sex:** ❑ M ❑ F
(Name Known As):				**Birth Date** / /
Full Address:		**Mobile phone no**:		**Home phone no.:** ( )
P.O. box:	**Suburb:**		**State:**	**Post Code:**
Do You Consent to receive SMS: ❑ **YES** ❑ **NO**	**Email:**			

Chose clinic because/Referred to clinic by **(please check one box)**:

❑ Family ❑ Friend ❑ Close to home/work ❑ Website ❑ Online Appointments ❑ Other

Marital status (circle one)
Single / Mar / Div / Sep / Wid / De facto

Occupation:

Ethnicity: (eg: Australian, Asian, Indian, European)

Do You Identify as:

❑ Aboriginal
❑ Torres Strait Islander
❑ Both Aboriginal and Torres Strait Islander
❑ Neither Aboriginal or Torres Strait Islander

MEDICARE& CONCESSION CARD INFORMATION

*(Please give your **Medicare card** to the receptionist.)*

Medicare Card no:	**Reference No & Expiry Date**:	**Name as per Medicare Card:**
Concession Card no:	**Concession Card Expiry:**	**Concession Type:** ❑ Health Care Card ❑ Pension Card ❑ DVA

Next of Kin Details (NOK)

Full Name:	**Mobile :**	**Home.:**
Patient's relationship to NOK: ❑ Parent ❑ Spouse/Partner ❑ Child ❑ Other		

IN CASE OF EMERGENCY ❑TICK IF SAME AS NEXT OF KIN

Name:	Relationship to patient:	Home phone no.: ( )	Mobile no.:

PRIVACY OF PATIENT INFORMATION AND MEDICAL INFORMATION

We require your consent to collect personal and health information about you. Centenary Medical Centre safeguards its confidentiality and privacy in accordance with the *Australian Privacy Principals.*
We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose and treat you and be proactive in your health care needs. This means we will use your information you provide in the following ways.

- Billing and administrative purposes including compliance with Medicare Australia
- Disclosure to others involved in your health care, including treating doctors & specialists outside this medical practice. This can occur through referral to other doctors, referral for medical tests and in the reports and results returned to us following these referrals.
- To contact you for the purpose of Recalls and Reminders

Patient/Guardian signature ***Date***

CENTENARY MEDICAL CENTRE

MEDICAL HISTORY FORM

First Name:	Surname:	DOB:

Past Medical History:	

Family History: (eg diabetes, heart disease, asthma, cancer)	

Current Medications: (including non- prescriptions)	

Allergies	
Medication / Food / Other	**Nature of Reaction**

Smoking History	Drinking History
Please tick: ❑ Current Smoker Year commenced ❑ Daily ❑ Less than weekly ❑ Weekly Number of Cigarettes: ❑ Ex-Smoker Year Quit ❑ Never Smoked	Please tick: ❑ Never ❑ Less than Monthly ❑ 1-2 days per Month ❑ 1-2 days per Week ❑ Everyday Number of Standard Drinks: Six or more standard drinks on one occasion: Please tick: ❑ Never ❑ Less than Monthly ❑ Monthly ❑ Weekly ❑ Daily or Almost Daily

Patients Signature _____ **Date** _____