Uraidla Family Practice - Patient Registration

We need this information to provide you best quality care. Our practice follows the RACGP guidelines for management of health information in private medical practice. This form complies with those standards. Your personal health information is kept private and secure, as required by privacy laws. If you have concerns, please leave blank and discuss with your GP.

Mr/Mrs/Miss/Ms ______________________________ ____________________________________

Surname Given Names

____________________ ____/_____/_____ _______________________

Preferred Name Date of Birth Gender

Marital Status (Please Circle) Married De Facto Single Divorced Widowed

Address ____________________________ _______________________ _________

Street Suburb Postcode

Postal Address ____

Phone – Home __________________ Work ____________________

Mobile_____________________ Permission to send information via SMS: YES/NO

Aboriginal or Torres Strait Islander Yes ☐ No ☐ (For Closing The Gap)

Are you of any other cultural ethnicity ? (details)___________________Country of Birth ______________

Medicare No. ___________________________________ Ref. No._______ Exp______/__________

Government Issued Pension/Health Care Card:______________________________Exp____/____/_____

Next of Kin ________________________ Relationship__________________ Phone_________________

Emergency Contact___________________ Relationship__________________Phone_________________

Occupation ____

Previous/Current GP____Phone________________________

Reminder Systems

We provide our patients with preventive care reminders e.g. immunisations, blood tests, annual health checks, skin checks, pap smears. Please indicate and sign the following:

I wish to have health reminders sent to me: Yes / No __________________________________

Please circle and sign

I consent to Reminders being sent via email:

Email ____

Accounts

Please note Children under sixteen years, Pensioners and Health Care Card Holders are Bulk Billed

Person responsible for account payment____

I declare the above information to be correct. I understand the privacy policy and the fee policy of the practice and undertake to pay for the services provided.

SIGNATURE_________________________________

Please turn over to complete medical information

Patient Registration – Medical History

Only information needed to assist in your health care is collected by the doctors, the nurse and the staff of this practice. This information is necessary to keep your medical record current. The information is kept confidential and would not be released to any third party without your signed authorisation. A full copy of our privacy policy is available in the waiting room and at reception.

I consent to having my health information and personal details collected to assist in my health care...   /   /

Medical History

Known Allergies: To anything (medications, insect bites, creams, food)

Details...

Do you smoke?   Yes/No . If yes for how many per day?...

Have you ever smoked? Yes/No If yes when did you stop ?...

Do you drink alcohol? Yes/No

If you do, how many days per week?........... How many standard drinks on those days?.......

Do you exercise Yes/No

If you do exercise what do you do?................................ How many times a week?........ and for how long?.........

Family History:

Marital Status – Married, single, divorced, widowed, de facto. (please circle)

Do you have any children?   Yes/No   If yes how many?   F...........M...................................

Parents: If still living do they have any specific health problems?

Mother...

Father..

If no longer living. What age did they pass away and what was the cause?

Mother...

Father..

Any other immediate family members with significant health problems?

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