

NEW PATIENT REGISTRATION FORM

This information is private and confidential and is for use in your clinical file only

PERSONAL DETAILS

Title: Mr Mrs Miss Ms Dr Other: _____

Gender Identity: Male Female Other Pronouns: He/Him/His She/Her/Hers They/Them/Theirs

First Name: _____ Middle Name: _____ DOB: _____

Surname: _____ Preferred Name: _____

Street Address: _____ Suburb: _____

State: _____ Postcode: _____ Postal Address Same as Street address

Postal Address: _____ Suburb: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email Address: _____ Consent to SMS Reminders? Yes No

Occupation: _____ Past Occupation: _____

HEALTH CARE DETAILS

Medicare Card Number _____ Reference No. _____ Expiry Date: _____

DVA Card - Type: GOLD WHITE Card Number _____ White Card Condition: _____

Concession Card Type: Health Care Card (Green) Pension Card (Blue) Commonwealth Seniors Card (Red)

Concession Card Number _____ Concession Card Expiry _____

EMERGENCY CONTACT DETAILS

Next of Kin Name: _____ Contact Number _____ Relationship _____

Emergency Contact: _____ Contact Number: _____ Relationship _____

CULTURAL IDENTITY

Country of Birth _____ Ethnicity (Birth Country of your parents) _____

Do you require a Translator? Yes No Do you require an interpreter service? Yes No

To assist with health initiatives – Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander None

CANCELLATION POLICY: Please telephone the surgery to cancel at least 4 hours prior to your appointment. **Failure to do so will result in a fee of \$40.00.** Payment of such fee will be required in full prior to any future appointments. Non cancelled appointments will be referred to as Did Not Attend (DNA) appointments and will be handled as per the cancellation policy.

Please be aware that our GP's at Warwick Medical Centre and Skin Clinic will not prescribe 'drugs of addiction' unless clinically indicated by the treating GP. It is our policy that GP's do not prescribe 'drugs of addictions' until they have obtained a full clinical picture. Patients are reminded that we have a zero-tolerance policy on issues relating to violence and aggression. Any such issues may result in transfer of your care.

Signature _____ Date: ____/____/____

PLEASE TURN OVER

MEDICATIONS

Current Medications: (including over the counter medication, vitamins, minerals and/or health supplements):

ALLERGIES

Do you have any allergies? No Yes - If so, please detail below:

Nature (Type of Allergy)	Reaction Type	Severity (Mild, Moderate, Severe)

HEALTH HISTORY

Do you have a history of any of the following? If so, please tick all that apply Blood Group _____

Asthma Hypertension Hypotension Diabetes (T1 T2 Gestational Pre-diabetic)

Chronic Illness: _____ Other: _____

Past operations: _____ Height (cm) : _____ Weight (kg) : _____ Waist Measurement: _____

FAMILY HISTORY

Do you have a history of any of the following conditions in your family? If so, please tick all that apply

Condition	Relationship	Condition	Relationship
<input type="checkbox"/> Diabetes - Type:		<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Mental Illness - Type:		<input type="checkbox"/> Cancer – Type	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Other (Give details)	

SOCIAL HISTORY

Do you smoke? No Yes - ___ per day Past smoking history: Nil Light Moderate Heavy

Quit Smoking - Which year did you quit? _____ Do you drink alcohol? No Yes - ___ per day / ___ days

Past drinking history: Nil Light Moderate Heavy Ceased - Which year did you stop drinking? _____

WOMENS HEALTH: Last Cervical Screening _____ Unknown Last Breast Check _____ Unknown

AGED 65+ PATIENTS: Last Influenza Vaccine _____ Unknown Last Pneumococcal Vaccine _____ Unknown

At Warwick Medical Centre and Skin Clinic we strive to provide high quality care, appropriate to meet our client's health care requirements. **By becoming a patient of Warwick Medical Centre and signing this new patient form I agree and consent to the following:** • I consent to the use of my personal health information by Warwick Medical Centre and Skin Clinic and other health care providers involved in my medical treatment and health care within this centre. • I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly in my personal health care or medical treatment. • I consent to receive follow up reminders and recalls (inclusive of preventative health), to be sent in line with my preferred method of contact. DATA SHARING: Our practice participates in sharing deidentified data for secondary purposes. Should you wish to opt out of sharing your deidentified data please notify reception.

Signature _____ Date _____/_____/_____

Printed Name _____ (If the patient is under 16 years the parent/guardian is to sign)