## New Patient Registration Form

Surname: ____________________________ First Name: ____________________________ Middle Initial: ________

Title: Mr / Mrs / Miss / Ms / Mstr Preferred Name: __________________________ Date of Birth: ________________

Residential Address: ______________________________________________________________________________

Postal Address: __________________________________________________________________________________

Home Ph: ________________________ Work: ________________________ Mobile: ___________________________

Email Address (18+ only): __________________________________________________________________________

Do you allow SMS: Yes: ☐ No: ☐

<u>PLEASE NOTE SMS IS USED FOR APPOINTMENT REMINDERS / RECALLS ONLY</u>

Medicare Card No: _____________________________ Ref No:(number in front of your name) ________ Exp: ____________

Dept Veterans Affairs Card No: _____________________________ Exp:_____________ White Card / Gold Card

Pension / Health Care Card Reference No: _____________________________ Exp: _____________

Do you identify as: Aboriginal ☐ Torres Strait Islander ☐ None ☐

Cultural Background:_____________________________________Occupation:______________________________

Language Spoken:__________________________________________ Interpreter Required: Yes / No

Do you plan on attending this practice on a regular basis? Yes ☐ No ☐ Unsure ☐

Next of Kin: _____________________________________Relationship to you: _______________________________

Home Ph: _______________________ Work Ph: _______________________ Mobile: _________________________

If the same as above, please write "as above"

Emergency Contact: ________________________________Relationship to you: ______________________________

Home Ph: _______________________ Work Ph: _______________________ Mobile: __________________________

**<u>Office Staff Only</u>**

Medicare Sighted: Yes / No Photo ID: Yes / No / Child Sighted Staff Member Initials: _______

**PTO to complete the other side**

**Please tick if you are interested in the following services:**

Skin Check ☐ Asthma Education ☐ Quit Smoking ☐ Diabetes Education ☐ Men's Health ☐

45-49yr Health Assessment ☐ 75yr and over Health Assessment ☐ Women's Health ☐

**Please tick: How did you hear about us?**

Practice Website: ☐ Medi2Apps Online Booking: ☐ Chemist: ☐ Website: ☐

Family / Friends: ☐ Signage / Shopping: ☐ Facebook: ☐ Gold Coast Info Pad: ☐

Other doctor: ☐ Google: ☐ Doctors at Australia Fair / Labrador Park Medical: ☐

Other: ________________________

**How did you book your appointment:** Online ☐ In person ☐ Telephone ☐

**<u>Patient information consent form:</u>**

We require your consent to collect personal information about you. Please read this information carefully and print your name and sign where indicated below. This information is used for the primary purpose of providing quality health care services for your health care needs. This practice has a strict policy on handling patient information. To ensure the security of personal information only authorised staff within the practice has access to this information. The information that you provide will only be used for:-

- Administrative purposes
- Email purposes – Practice updates and newsletters
- Billing purposes, including compliance with Medicare Australia requirements
- Disclosure to others involved in your care, i.e. for referral purposes, case conferences, medical tests or results.

In other situations we would not disclose your personal information without your consent.

Any children under the age of 16 years of age must be accompanied by a parent or guardian.

**<u>Restricted Drug Policy:</u>**

Patients requesting prescriptions for drugs MUST adhere to the following guidelines:

- Be in a position to have documentary evidence justify the prescription
- Produce further proof if identity in addition to your Medicare Card

All prescriptions for restricted drugs will be verified with the following government agencies:

- Medicare Australia
- Queensland Health Drugs of Dependency Unit

I have read this information above and fully understand the content. I consent to the handling of my information by Doctors at Southport Park for the purposes set above.

**Patients Name**: ________________________________________ **Date of birth:** ____________________________

**Signature: (Parent/Guardian to sign if under 16)** ______________________________________ **Date:** _________________

**PLEASE NOTE: PATIENTS THAT MISS ANY APPOINTMENTS WITHOUT GIVING STAFF FOUR HOURS NOTICE WILL BE CHARGED $40.00.**

# Doctors at Southport Park - Medical History Form

**Name:** **DOB:**

**Allergies:**

Do you suffer from any allergies? Yes ☐ No ☐

If so, please specify: ……………………………………………………………………………………………..

**Past Medical History:**

- Have you been diagnosed with any of the following: Yes ☐ No ☐

Asthma Cancer Diabetes Arthritis

Chronic Heart Disease Other: ……………………………………………..

- Have you ever had surgery or been hospitalised? Yes ☐ No ☐

Please specify: ………………………………………………………………………………..…………………………..
…………………………………………………………………………………………………………………………

**Family History: i.e. Heart Disease, Diabetes etc**

Has any family member been diagnosed with any chronic disease?

For example: Diabetes, Heart Disease etc? Yes ☐ No ☐

Known Disease: ………………………………………………………………………………………………….

**Women:**

How long ago was your last pap smear? .........................................................

How long ago was your last mammogram? .......................................................

How long ago was your last breast ultrasound?................................................

**Men:**
Have you ever had a prostate check? Yes ☐ No ☐

If so, when? ……………………………………………………………………………

**Smoking History:**

Do you or have you ever smoked? Yes ☐ No ☐

Year started: ……………………………….. Year stopped: ……………………………………………

How many of the following do you smoke per day?

Cigarettes ……………. Cigars . …………….. Pipe ………………..

**Alcohol consumption:**
How often do you consume alcohol?

Never Monthly or less 2-4 days/month 2-3 days/week 4+ days/week

When drinking the number of standard drinks consumed:

1-2 3-4 5-6 7-9 10+

How long has it been since your last tetanus? ……………………………………………………

**Would you like to register with My Health here at this practice and upload your summary?**
Yes No

**I certify that the information supplied is true and correct to the best of my knowledge.**

Signature: ……………………………………………………………………………………………………

Date: ………………………………………………………………………………………………………….

**Please note:** Undisclosed information, or inaccuracies in the information provided, could result in an adverse outcome in relation to your medical treatment.