

### 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  Mast  Other: \_\_\_\_\_

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

First Name:	Middle Name:	D.O.B:
Surname:	Preferred Name:	
Street Address:		
Suburb:	State:	Postcode:
Occupation:		
Mobile Phone:	Home Phone:	
Consent to SMS Reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address:		



#### GUARDIAN DETAILS – (for patients <17 years of age) & EMERGENCY CONTACT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### EMERGENCY CONTACT

	Name	Contact Number	Relationship
Next Of Kin			
Emergency Contact			



#### 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

#### 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



#### ALLERGIES

Do you have any allergies?  No  Yes - If so, please list bellow:

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

**Please Turn Over**

## 🕒 HEALTH HISTORY

Medication: including over the counter medication, vitamins, minerals and/or health supplements

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:

## 🧬 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 *Normal/Abnormal* Last Breast Check \_\_\_\_\_  Unknown *Normal/Abnormal*

**AGED 65+ PATIENTS:** Last Influenza Vaccine \_\_\_\_\_  Unknown Last Pneumococcal Vaccine \_\_\_\_\_  Unknown

At Alkimos Family Practice we strive to provide high quality care, suitable to meet our client's health care requirements.

**PLEASE READ THE FOLLOWING - By becoming a patient of Alkimos Family Practice and signing this new patient form I agree and consent to:**

- I consent to the use of HEIDI to assist in my consultation to help provide a better healthcare experience and I can opt-out during my consultation
- I consent to the use of my personal health information by Alkimos Family Practice and other health care providers involved in my medical treatment and health care through Everest Medical Group (s).
  - 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 give permission to upload to My Health Record (Should I change my mind; I will opt out in MyGov)
  - I consent to receive SMS notifications unless stated otherwise. I understand I can opt out at any time.

**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.

**CANCELLATION POLICY:** Please telephone the surgery to cancel at least 2 hours prior to your GP appointment and 24 hours prior to your Allied Health. Failure to do so will result in a fee of \$40.00 for missing GP appointment and will result in a FULL fee charged for missing Allied Health appointment. 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.

**DRUGS OF ADDICTION POLICY:** Please be aware that our GP's at Alkimos Family Practice will not prescribe 'drugs of addiction' to new patients and in the case of existing patients, drugs of addiction will only be considered when clinically indicated by the treating GP. It is our policy that GP's do not prescribe 'drugs of addiction' until they have obtained a full clinical picture.

**ZERO TOLERANCE POLICY:** Patients are reminded that Alkimos Family Practice has a zero-tolerance policy on issues relating to violence and aggression. Any such issues may result in transfer of your care.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Print \_\_\_\_\_