DOCTORS @ GOLDFIELDS PLAZA

Patient Registration form

Surname:	Title: ☐ Mr ☐ Mrs ☐ Dr ☐ Miss ☐ Ms
First Name:	**Preferred Name:**
DOB:	
Residential Address:	
Suburb:	**Postcode:**
Mobile: **Home:**	**Work:**
Email Address:	

Country of Birth:	**Preferred Language:**
Do you **Identify** as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither	
If **YES** (ATSI) are you registered for the "Close the Gap" Program: ☐ YES ☐ NO	

Medicare Card Number:	Ref:	Expiry:
Pension Card Number:		Expiry:
Healthcare Card Number:		Expiry:
Dept of Veteran Affairs Card Number:		Expiry:

Occupation:
Relationship Status: ☐ Single ☐ Married ☐ De Facto ☐ Divorced ☐ Widow

Next of Kin:	Relationship:
Phone Number:	
Emergency Contact:	Relationship:
Phone Number:	

☐ I give permission for my Health Record summaries to be uploaded to the National My Health System.

☐ I hereby give express permission to Doctors@Goldfields Medical Centre staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf.
I acknowledge that I am wholly responsible to arrange any further appointments to discuss test results conducted by my Doctor always.
I give permission to be notified by letter, phone, email or text message for all Routine Recalls and Reminders.
I give consent to access the Pap Smear Register. - *If required.*

HIC Online, For Eligible Bulk Bill Patients
I hereby authorise Doctors@Goldfields Medical Centre to process my claim through Medicare Australia

Signed ______________________________ **Dated**____________________

Please tick if ☐ Parent ☐ Guardian

Please TURN OVER to Complete New Patient Medical History Form

New Patient Medical History Form

All information is kept private and confidential and will help our doctors to give you a better long-term treatment plan for your health requirements.

Allergies;
Are you allergic to any medication or materials? **i.e.: Penicillin, Latex?** ☐ YES ☐ NO
If **YES** what are you allergic too?

____

Medication;
Are you taking any medication? *(including over the counter medication, vitamins and minerals)*
☐ YES ☐ NO
If **YES** what are you taking?

____

____

Social History;		
Tobacco use: ☐ YES ☐ NO _____________ Day/Week		☐ I Quit Smoking ____________
Alcohol use: ☐ YES ☐ NO	Days per Week ___________	Standard drinks per day__________

Your Health and Family History;
Your History; – Do you have, or have you had a history of:
☐ Asthma ☐ Diabetes (Type 1 /Type 2) ☐ Hypertension ☐ Chronic Illness ☐ Depression/anxiety

☐ Thyroid Disease ☐ Indigestion or Reflux ☐ Stroke ☐ Arthritis or Back pain ☐ Other ☐**NIL**
Please Give Details:

____

____

____

Your Family History;
Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer ☐**NIL**
Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐**NIL**
Please Give Details:

____

____

FEMALES - When did you last have;
Pap Smear - Date: _______________ ☐ Not sure ☐ Never
Breast Screen - Date: ___________________ ☐ Not sure ☐ Never
Are you Pregnant? ☐ YES ☐ NO
If **YES** when are you due: _________________________________

Is there anything else you would like to tell us about your general health?

____

Admin Internal use. ☐Keyed into BP ☐Medicare checked Initials ________ Scanned into BP initials ________ DR Initials_______