HELENSVALE PLAZA MEDICAL CENTRE

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 details to be registered with my Health Record and Summaries to be Uploaded to the National My Health system.

☐ I hereby give express permission to Pimpama Family Medical Practice 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 Pimpama Family Medical Practice 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 ☐ Stoke ☐ 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_____