HELENSVALE PLAZA
MEDICAL CENTRE

# Patient Registration Form

Title Dr/ *Mr / Mrs / Miss / Ms / Master*

Surname _____ First Name_____

Date of Birth _____ Preferred Name _____

Are you of Aboriginal descent or Torres Strait Islander descent?
☐ *No* ☐ *Yes - Aboriginal* ☐ *Yes – Torres Strait Islander* ☐ *Both*

What is your preferred language _____Country of Birth _____

Address: _____

Suburb _____ Postcode _____

Telephone Home _____ Work _____

Mobile _____ Email _____

Medicare Card Number _____ ref no _____ Expiry_____

Pension Card Number _____ Expiry _____

Healthcare Card Number _____ Expiry _____

Dept of Veteran Affairs Card Number _____ Expiry _____

Occupation_____ Relationship Status _____

Next of Kin Name: _____Phone _____Relationship _____

Emergency Contact _____ Phone _____ Relationship _____

☐ 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 Helensvale Plaza 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 at all times.
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 Helensvale Plaza Medical Centre to process my claim through Medicare Australia

**Signed** _____

**Dated**_____ Please tick if ☐ Parent ☐ Guardian

***How did you hear about us?*** ***(Please tick)***
☐ Google Search ☐ Health Engine ☐ Website ☐ Facebook ☐ Family / Friend ☐ Walk Past ☐ Other

**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.

Surname: _____ First_____ D.O.B_____

Who is or was your GP? _____ Suburb_____Phone_____

Current Height_____ Weight_____

Are you currently taking any medication?

_____

_____

Are you currently undergoing any medical treatment or had any operations recently?

_____

Do you smoke please tick ☐ Never ☐ Smoker ☐ Ex-Smoker ☐ I Quit Date_____

Alcohol Usage ☐ Never ☐ Days per week_____ Standard Drinks per day_____

Are you allergic to any medication or materials? i.e Penicillin. Latex? ☐ Yes ☐ No

If yes what are you allergic too?

| | | | | | |
|---|---|---|---|---|---|
| | High/Low Blood Pressure | | Epilepsy | | Heart Surgery/Attack |
| | Rheumatic Fever | | Diabetes Type 1 ☐ Type 2 ☐ | | Heart Complaint |
| | Allergies or Hives | | Hepatitis A, B, C | | Asthma or Breathing Problems |
| | Arthritis or Back Pain | | Anaemia | | Steroid Therapy |
| | Stroke | | Contact with HIV/AIDS | | Kidney Disease |
| | Emphysema | | Stomach Ulcers | | Tuberculosis |
| | Bleeding Disorder | | Thyroid Disease | | Sinus Therapy |
| | Depression or Mental illness | | Diarrhoea or bowel trouble | | Indigestion or reflux |
| | Artificial Joint | | Liver Disease | | Cancer |

Have you ever had any of the following? Please tick those that apply on the left hand side.

Ladies, Last Pap Smear_____ are you pregnant? _____if yes when are you due?

What brings you to our practice today _____

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 _____