**Kingsgrove Medical Centre**

New Patient Registration Form

**Please take a few moments to read and complete the following two pages,**

**We need this information to provide the best quality care.**

**Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.**

SECTION A: Personal Details

TITLE: \_\_\_\_\_\_ FAMILY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GIVEN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MIDDLE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREFERRED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH (dd/mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: Male  Female

MARITAL STATUS: Single  Married Defacto  Separated Divorced  Widowed 

CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander Origin?

No Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander 

Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBURB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTCODE:\_\_\_\_\_\_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBURB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTCODE:\_\_\_\_\_\_\_\_\_

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICARE CARD NO.: REF NO.(PLACE ON CARD):EXPIRY DATE: /

PENSION CARD TYPE: Pensioner Concession Card  Health Care Card Commonwealth Seniors Health Card 

PENSION/HCC NO.:   EXPIRY DATE: //

DVA NO.: DVA Card Colour: Gold White Lilac Orange 

If your DVA card covers certain conditions, please state condition(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEXT OF KIN (NOK) DETAILS (e.g. relation or family member):

Name of NOK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOK Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOK Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT (e.g. close friend or neighbour, someone local, if possible not the same as NOK):

Name of *‘Emergency Contact’*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kingsgrove Medical Centre**

New Patient Registration Form

This information is required for processing Medicare claims; Medicare will not accept claims for minors.

Is the HEAD OF FAMILY a current patient of this practice? Yes  Please provide ***full name*** and ***DOB*** only below.

  No  Please provide ***full*** ***details*** below.

HEAD OF FAMILY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH (dd/mm/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO CHILD: Parent  Legal Guardian Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBURB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTCODE:\_\_\_\_\_\_\_\_\_\_

MEDICARE CARD NO.: REF NO.(PLACE ON CARD):EXPIRY DATE: /

CONTACT PHONE NO.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECTION B: **FOR PATIENTS UNDER 16**

SECTION C: Medical History

Smoking Status: Non-Smoker Smoker Ex-Smoker 

|  |  |  |
| --- | --- | --- |
| PRODUCT/CAUSE  Do you have any known allergies? (E.g. medication, food, bees etc.): Yes  please provide details below No  | REACTION | SEVERITY |
|  |  |  |
|  |  |  |
|  |  |  |
| ADMINISTRATION USE ONLY  The above allergies & smoking details have been entered into the patient record Nurse Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

Do you take any regular medication (Medications and doses, Complementary Medicines and Doses)

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Past Medical History

Please List All Significant Past Medical History

|  |  |  |
| --- | --- | --- |
| **I have read & understand all information provided above regarding fees, privacy & freedom of information.**  **I also am aware that at the conclusion of all consultations there will be a request for full payment of the account.** | | |
| **NAME:** | **SIGNATURE:** | **DATE:** |

SIGNED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certain medical examinations – such as medicals, legal reports & commercial driver’s licences are not claimable from Medicare.

If you require any further information regarding cost of these please ask reception staff.

Full Payment is required on day for Workcover claims that do not currently have a claim number. You are then able to follow this up with your claim agent.

**Privacy:**

Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare services it is important that you are aware of how any personal information collected by this practice is used.

The personal information collected is that deemed necessary to best attend to, and treat the presenting health condition(s). Personal information is primarily used within the practice, but sometimes it is used to ensure quality and continuity of health care for you and must be partially or fully disclosed to others outside of the organisation, depending on the circumstances. e.g: when referring to a specialist medical practitioner or when requesting blood tests, urine tests, x-rays etc; when itemising accounts for Medicare.

**Freedom of information:**

All patient files that include personal information, test results etc. are the property of this practice. However, should you choose to visit another Doctor at any time, copies of the appropriate files can be forwarded on receipt of your written request. Under no circumstance will this practice divulge personal information without your prior written consent.

SECTION D: Important Practice information