New Patient Registration Form

Twin Waters MEDICAL PRACTICE

Patient Information						
Title	☐ Mr	☐ Mrs	☐ Ms	☐ Dr	☐Master	☐Miss
Name	First:		Middle:		Last:	
Gender	☐ Male	☐ Female	☐ Other	Date of Birth: _____/_____/_____		

Contact Information	
Cultural Identity	Do you identify as being Aboriginal and/or Torres Strait Islander? ☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes – both Aboriginal and Torres Strait Islander
Contact	Mobile Phone: Home Phone: Work:
Email	
Language	If English is not your first language, do you require an interpreter? ☐ No ☐ Yes - Please elaborate _____
Address	____ / ____ _____ _____ _____ _____ Unit/street number Street Name City State Postcode
How would you prefer to be contacted?	☐ Mobile ☐ Home Phone ☐ Email ☐ Post

Consent

- Can we SMS or leave a message on your mobile if we are unable to get in contact with you regarding an appointment? ☐ Yes ☐ No
- Do you consent for Twin Waters Medical Centre leaving a message with family member/Friend if we are unable to get in contact with you? ☐ Yes ☐ No
  if yes please specify who in relation to you:_____
- Do you give consent for Twin Waters Medical Centre to upload current and future Health Summaries to My Health Records? ☐ Yes ☐ No

Twin Waters Medical Practoce operates in accordance with the privacy Act (1988) and Privacy Amendment Act (2012). I Consent to disclosure/use of my personal health informatio0n to other health providers directly involved in my personal health care or medical treatment and agree that my health records may be de-identified for use as shared patient data.

☐ Yes

☐ No

Please sign once you have read, understood and agreed to the above consent. _____

Please also answer questions on Page 2.

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Other Information:		
Medicare Number:	Ref:	Expiry: ___/_____
Concession (Pension/Health Care) Card Number:		Expiry: ___/_____
Dept. of Veterans' Affairs File Number: ☐ Gold ☐ White		Expiry: ___/_____
Occupation:		
Next of Kin: _____	Relationship: _____	Phone Number: _____
Emergency Contact: _____	Relationship: _____	Phone Number: _____

Your Health Information

Do you have a Power of Attorney in Place ☐ Yes ☐ No

Do you have a Advance Health Directive in place ☐ Yes ☐ No

_____

Allergies - Do you have any allergies or are you sensitive to drugs or dressings?

☐ Yes ☐ No (if yes, please describe below)

_____

Current Medications – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

_____

What is your body Mass Index (BMI)?

Weight: _____ Height: _____ Waist: _____

MEDICAL HISTORY - Do you have, or have you had any significant past medical history? ☐ Yes (please list) ☐ No

_____

Are all childhood immunisations up to date?

☐ Yes ☐ No

Smoking

☐ Non -smoker ☐ ex- smoker Ceased – date:_____ ☐ smoker – how many in a day:_____

Alcohol

☐ No ☐ Yes - how many days during the week ____ / how many in one day _____

Past drinker: ☐ No ☐ Occasional ☐ moderate ☐ heavy

Family Health History Information

Have you or any members of your family been diagnosed with:

☐ Heart Disease : Family Member _____

☐ Asthma: Family Member _____

☐ Diabetes : Family Member _____

☐ Hypertension (high blood pressure) : Family Member _____

☐ Depression: Family Member _____

☐ Cancer – type: _____ Family Member _____

☐ Other significant - provide details: Family Member _____

Mother alive? ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

Father alive? ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____