# NEW PATIENT REGISTRATION FORM

CAMMERAY MEDICAL PRACTICE

This information will help us provide the best quality care. This form complies with the RACGP Standards for General Practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

## PERSONAL DETAILS:

Title: _____ Given Name(s): _____ Surname: _____

Date Of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Medicare Card Number: _____ Patient Reference Number: ____ Expiry Date: ____/____/_____

Pension / Health Care Card / Veteran Affairs Number: _____

Type Of Veterans Affairs Card: _____

Occupation: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

Email Address: _____

Residential Address (compulsory): _____

Suburb: _____ Postcode: _____

Postal Address (if different): _____

## NEXT OF KIN

Name: _____ Relationship To You: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

## EMERGENCY CONTACT (IF DIFFERENT TO NEXT OF KIN)

Name: _____ Relationship To You: _____

Phone (Home): _____ (Work): _____ (Mobile): _____

## FOR CHILDREN UNDER 16

Mother's Name: _____ Father's Name: _____

Parent Medicare Number: _____ Reference Number: ___ (Parent) Date of Birth: ___/___/_____

Mother's Phone Number: _____ Father's Phone Number: _____

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**BRIEF MEDICAL HISTORY:**

**MEDICAL HISTORY:** (Chronic diseases / illnesses, operations etc.)

**REGULAR MEDICINES AND DOSES:** (Please state complementary medicines and doses as well)

**ALLERGIES / INTOLERANCES:** (Please state what to and describe your reaction)

**SMOKER STATUS:** ☐ Never smoker ☐ Ex smoker ☐ Smoker

**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 ☐ ATSI

Other Cultural Background: _____

Is English your first language?: ☐ Yes ☐ No

If not, please specify the language?: _____

Do you require an interpreter?: ☐ Yes ☐ No

**CONSENT**

Our practice sends reminders for appointments by SMS. We also send reminders by mail, telephone or SMS for vaccinations, cervical screenings and other health reviews.

I consent to be contacted with reminders to help me maintain my health?: ☐ Yes ☐ No

Signature of Patient or Guardian: _____ Date: ____/____/_____