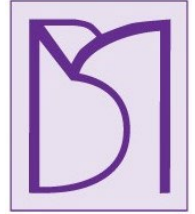


New Patient Registration



Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr	
First Name:	Surname:
Date of Birth:	

Birth gender:
Gender identity:
Pronouns: <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs

Address:
Postal Address (If different from above):
Phone Numbers: (H) (M) (W)
Email Address:

Are you of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander
Country of Birth:
Cultural background:

Occupation:

Emergency Contact / Next of Kin:
Name:
Relationship to patient:
Phone Numbers: (H) (M) (W)

Billing Details (Please tick if you have any of the following):			
<input type="checkbox"/> Medicare Card	Number:	Ref:	Expiry:
<input type="checkbox"/> DVA Gold Card	Number:		Expiry:
<input type="checkbox"/> DVA White Card	Number:		Expiry:
<input type="checkbox"/> Pension Card	Number:		Expiry:
<input type="checkbox"/> Healthcare Card	Number:		Expiry:
<input type="checkbox"/> Commonwealth Seniors	Number:		Expiry:

Current Regular Medications:	
(including all over the counter medications/vitamins etc)	- - - - - -

Allergies:	
(Include reaction)	<input type="checkbox"/> Nil known - -

History:	
Active Current medical issues	- - - - -
Inactive (past operations, illnesses and injuries)	- - - - -

Alcohol:	
Current:	<input type="checkbox"/> Non drinker Days per week: _____ Drinks per session: _____
Past:	<input type="checkbox"/> Nil <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy

Smoking:	
Current:	<input type="checkbox"/> Non smoker <input type="checkbox"/> Ex Smoker <input type="checkbox"/> Smoker Quantity per day: _____ Year Started: _____
Past: (If applicable)	Quantity per day: _____ Year Stopped: _____

Social History:			
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Defacto
	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Sexuality:	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Homosexual	<input type="checkbox"/> Bisexual

Family History:	
	<input type="checkbox"/> Unknown (eg. Adopted) <input type="checkbox"/> No significant family history
Mother:	Alive <input type="checkbox"/> Yes <input type="checkbox"/> No Age at death: _____ Cause: _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Other:
Father:	Alive <input type="checkbox"/> Yes <input type="checkbox"/> No Age at death: _____ Cause: _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Other:

NEW PATIENT CONSENT

Y / N I consent to receiving recalls and reminders regarding my personal health care and medical treatment

Y / N I consent to the use of my personal health information by Bacchus Marsh Medical Centre and other health providers involved in my medical treatment and health care

Y / N I consent to the disclosure of my personal health information by the Bacchus Marsh Medical Centre to other health providers involved in my personal health care or medical treatment

Y / N I consent to the use of my de-identified information for research purposes

Signature: _____

Parent / Guardian Name: _____

Date: _____