New Patient Registration

Title: ☐ Mr	☐ Mrs	☐ Ms	☐ Miss	☐ Dr	
First Name:			**Surname:**		
Date of Birth:					

Birth gender:			
Gender identity:			
Pronouns: ☐ She/Her/Hers	☐ He/Him/His	☐ 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? ☐ No	☐ Aboriginal	☐ 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):			
☐ Medicare Card	Number:	Ref:	Expiry:
☐ DVA Gold Card	Number:		Expiry:
☐ DVA White Card	Number:		Expiry:
☐ Pension Card	Number:		Expiry:
☐ Healthcare Card	Number:		Expiry:
☐ Commonwealth Seniors	Number:		Expiry:

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

Allergies:	
(Include reaction)	☐ Nil known - -

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

Alcohol:	
Current:	☐ Non drinker Days per week: ____ Drinks per session: ____
Past:	☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Smoking:	
Current:	☐ Non smoker ☐ Ex Smoker ☐ Smoker Quantity per day: ____ Year Started: ____
Past: (If applicable)	Quantity per day: ____ Year Stopped: ____

Social History:			
Marital Status:	☐ Single ☐ Separated	☐ Married ☐ Divorced	☐ Defacto ☐ Widowed
Sexuality:	☐ Heterosexual	☐ Homosexual	☐ Bisexual

Family History:	
	☐ Unknown (eg. Adopted) ☐ No significant family history
Mother:	Alive ☐ Yes ☐ No Age at death: _____ Cause: _____ ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer ☐ Other:
Father:	Alive ☐ Yes ☐ No Age at death: _____ Cause: _____ ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ 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: _____