

# PATIENT REGISTRATION FORM

(To be completed by all new patients)

## A. DEMOGRAPHIC INFORMATION

Family Name			
Given Names			
Date of Birth			
Street Address			
Suburb and Post Code			
Home Phone			Work phone:
Mobile Phone			
Email			
Occupation			
Are you of Aboriginal or Torres Strait Islander origin?	<input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> Yes, both Aboriginal and Torres Strait Islander <input type="checkbox"/> No		
Country of birth			
Cultural back ground			
Main language spoken at home	<input type="checkbox"/> English <input type="checkbox"/> Other (specify)		
Interpreter needed	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Veterans status	<input type="checkbox"/> Member/ex member of Australian armed forces <input type="checkbox"/> Partner/child		
Next of Kin	Name	Phone number	
	Relationship		
Emergency Contact (Someone we can contact if needed urgently)	Name	Phone number	
Medicare Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Ref No <input type="text"/>	Expiry Date /
DVA Number <input type="checkbox"/> Gold <input type="checkbox"/> White	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	Expiry Date /
Pension Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Expiry Date /
Health Care Card Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Expiry Date /
Marital Status			
Private Health Insurance	<input type="checkbox"/> Yes (Name of insurer) _____ <input type="checkbox"/> No		

## B. FAMILY HEALTH HISTORY

Have any members of your family had?

Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grand parent	<input type="checkbox"/> Other
Heart disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grand parent	<input type="checkbox"/> Other
Stroke	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grand parent	<input type="checkbox"/> Other
Asthma	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grand parent	<input type="checkbox"/> Other
Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Brother/sister	<input type="checkbox"/> Grand parent	<input type="checkbox"/> Other

## C. PERSONAL HEALTH HISTORY

Do you have or had a history of? (describe below)

- |                                       |  |                                   |
|---------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Operations   | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Other    |

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