ABERFOYLE PARK FAMILY PRACTICE

PATIENT REGISTRATION FORM

PLEASE HAND THIS PAGE BACK TO STAFF ONCE COMPLETED, DO NOT LEAVE ON FRONT DESK.

Title (please circle)	**Mr Mrs Miss Master Ms Dr Other.....**	
First Name (as it appears on Medicare Card)		
Surname (as it appears on Medicare Card)		
Date of Birth		
Medicare Card No.	_ _ _ _ _ _ _ _ _ _ _ Ref No. _ Expiry Date: _ _/_ _	
DVA Number (Dept of Veterans' Affairs)	_ _ _ _ _ _ _ _ Expiry Date: _ _/_ _ /_ _	
Pension No. (Centrelink)	_ _ _ _ _ _ _ _ _ _ Expiry Date: _ _/_ _/_ _	
Health Care Card No. (Centrelink)	_ _ _ _ _ _ _ _ _ _ Expiry Date: _ _/_ _/_ _	
Home Address (Residential Address)		
Postal Address (if different from above)		
Home Phone No:		**Work Phone No:**
Mobile No:	Do you consent to SMS reminder? Yes / No (Please circle)	
Email:		
Patient's Occupation		
Next of Kin	Name:_____ PH: _____ Relationship to you (i.e. mother) _____	
Emergency Contact	Name: _____ PH: _____ Relationship to you (i.e. mother) _____	

Knowing your cultural background can help us provide health care that meets your individual needs
Are you of Aboriginal or Torres Strait Islander Origin?

□ No □ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander

□ Other cultural background (e.g. Mediterranean, Asian, African) _____

Country of Birth	
How did you hear about our clinic?	**Website Facebook Flyer/Brochure Yellow Pages Online** Drive By Word of Mouth Other.....

Signature: _____ Date: _____

PLEASE TAKE THIS COMPLETED FORM INTO THE DOCTOR WITH YOU

NAME: _____ **DOB:** _____

ALLERGIES: DO YOU HAVE ANY ALLERGIES OR ARE YOU SENSITIVE TO ANY DRUGS, FOODS OR DRESSINGS? ☐ Yes ☐ No REACTIONS TO: _____

DETAILS: _____

PAST MEDICAL HISTORY/ OPERATIONS:

DETAILS: _____

_____

CURRENT MEDICATIONS:

_____

_____

SIGNIFICANT FAMILY HISTORY: NIL KNOWN ☐

MOTHER Alive: Yes ☐ No ☐
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER site _____
- ☐ DEPRESSION
- ☐ HEART DISEASE
- ☐ ASTHMA
- ☐ OTHER _____

FATHER Alive: Yes ☐ No ☐
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER site _____
- ☐ DEPRESSION
- ☐ HEART DISEASE
- ☐ ASTHMA
- ☐ OTHER _____

OCCUPATION: _____

ARE YOU AN ELITE ATHLETE: Yes ☐ No ☐

DO YOU HAVE A CARER? Yes ☐ No ☐ **ARE YOU A CARER?** Yes ☐ No ☐

ALCOHOL INTAKE:

NON DRINKER ☐

DRINKER: DAYS PER WEEK _____ STANDARD DRINKS PER DAY _____

PAST DRINKER: YEAR STARTED _____ YEAR STOPPED _____

SMOKING HISTORY:

☐ NEVER SMOKED ☐ EX- SMOKER ☐ SMOKER ☐ CIGARETTES ☐ PIPE ☐ OTHER _____

PAST SMOKING HISTORY: ☐ LIGHT ☐ MODERATE ☐ HEAVY

YEAR STARTED _____ YEAR STOPPED _____

IMMUNISATION HISTORY:

ADULT: DATE OF LAST INFLUENZA IMMUNISATION _____ ☐ Not Known

(IF FOR CHILD): IS YOUR CHILD'S IMMUNISATION HISTORY UP TO DATE? ☐ Yes ☐ No

WOMEN ONLY:

ARE YOU BREAST FEEDING? Yes ☐ No ☐ DATE OF LAST PAP SMEAR: _____

If aged 50 or over – DATE OF LAST MAMMOGRAM: _____

MEN: If aged over 50 or over have you ever had a prostate check? ☐ Yes ☐ No

Your privacy is important to us. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff. The information collected in this form will be kept confidential at all times. All staff employed at this clinic are bound by a confidentiality agreement in accordance with accreditation standard.