Doctors at Australia Fair

New Patient Registration Form

Surname: _____ First Name: _____ Middle Initial: _____

Title: Mr / Mrs / Miss / Ms / Mstr Preferred Name: _____ Date of Birth: _____

Residential Address: _____

Postal Address: _____

Home Ph: _____ Work: _____ Mobile: _____

Email Address (18+ only): _____

Do you allow SMS: Yes: ☐ No: ☐

PLEASE NOTE SMS IS USED FOR APPOINTMENT REMINDERS / RECALLS ONLY

Medicare Card No: _____ Ref No:(number in front of your name) _____ Exp: _____

Dept Veterans Affairs Card No: _____ Exp:_____ White Card / Gold Card

Pension / Health Care Card Reference No: _____ Exp: _____

Do you identify as: Aboriginal ☐ Torres Strait Islander ☐ None ☐

Cultural Background:_____ Occupation:_____

Language Spoken:_____ Interpreter Required: Yes / No

Do you plan on attending this practice on a regular basis? Yes ☐ No ☐ Unsure ☐

Next of Kin: _____ Relationship to you: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

If the same as above, please write “as above”

Emergency Contact: _____ Relationship to you: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Office Staff Only

Medicare Sighted: Yes / No Photo ID: Yes / No / Child Sighted Staff Member Initials: _____

PTO to complete the other side

Please tick if you are interested in the following services:

Skin Check ☐ Asthma Education ☐ Quit Smoking ☐ Diabetes Education ☐ Men's Health ☐

45-49yr Health Assessment ☐ 75yr and over Health Assessment ☐ Women's Health ☐

Please tick: How did you hear about us?

Letterbox drop: ☐ Practice Website: ☐ Health Engine Online Booking: ☐ Chemist: ☐

Email: ☐ Family / Friends: ☐ Shopping: ☐ Gold Coast Bulletin: ☐ Shopper Docket: ☐

White Pages Online: ☐ Gold Coast Sun Newspaper: ☐ Booth in Shopping Centre: ☐

Yellow Pages Online: ☐ Yellow Pages Directory ☐ Children By Choice: ☐

Other (inc previous surgery): _____ Signage (which location): _____

How did you book your appointment: Online ☐ In person ☐ Telephone ☐

Patient information consent form:

We require your consent to collect personal information about you. Please read this information carefully and print your name and sign where indicated below. This information is used for the primary purpose of providing quality health care services for your health care needs. This practice has a strict policy on handling patient information. To ensure the security of personal information only authorised staff within the practice has access to this information. The information that you provide will only be used for:-

- Administrative purposes
- Email purposes – Practice updates and newsletters
- Billing purposes, including compliance with Medicare Australia requirements
- Disclosure to others involved in your care, i.e. for referral purposes, case conferences, medical tests or results.

In other situations we would not disclose your personal information without your consent.

Any children under the age of 16 years of age must be accompanied by a parent or guardian.

Restricted Drug Policy:

Patients requesting prescriptions for drugs MUST adhere to the following guidelines:

- Be in a position to have documentary evidence justify the prescription
- Produce further proof if identity in addition to your Medicare Card

All prescriptions for restricted drugs will be verified with the following government agencies:

- Medicare Australia
- Queensland Health Drugs of Dependency Unit

I have read this information above and fully understand the content. I consent to the handling of my information by Doctors at Australia Fair for the purposes set above.

Patients Name: _____**Date of birth:**_____

Signature: (Parent/Guardian to sign if under 16)_____**Date:** _____

PLEASE NOTE: PATIENTS THAT MISS ANY APPOINTMENTS WITHOUT GIVING STAFF ONE HOURS NOTICE WILL BE CHARGED $10-$20.

Doctors at Southport Park - Medical History Form

Full Name: _____ **DOB:** _____

Allergies: Please Tick

Do you suffer from any allergies? Nil Known ☐ Yes ☐ If so, please specify: ……..……

Current Medications: …… ..

Past Medical History:

-Have you been diagnosed with any of the following: Yes ☐ No ☐

Asthma Cancer Diabetes Arthritis Chronic Heart Disease Other: ……..

-Have you ever had surgery or been hospitalised for anything major? Yes ☐ No ☐

Please specify: ……..……..

Family History: i.e. Heart Disease, Stroke, Breast Cancer, Diabetes, Asthma, Heart Attack, Bowel Cancer etc

Has any family member been diagnosed with any chronic disease? Yes ☐ No ☐

If so, please specify who and which condition: ……..

……

Women:

When was your last pap smear? (month and year) .....Normal Result? Yes ☐ No ☐

When was your last mammogram? (month and year).....Normal Result? Yes ☐ No ☐

When was your last breast ultrasound? (month and year)….....Normal Result? Yes ☐ No ☐

Men:
Have you ever had a prostate check? Yes ☐ No ☐ If so, when? ……

Smoking History:

Do you or have you ever smoked? Yes ☐ No ☐ Year started: …… Year stopped: …….

How many of the following do you smoke per day? Cigarettes ……..…… Cigars . …… Pipe ……..

Alcohol consumption: (Please circle)

How often do you consume alcohol? Never Monthly or less 2-4 times a month 2-3 times per week 4+ times per week

When drinking, the number of standard drinks consumed: 1-2 3-4 5-6 7-9 10+

What year did you have your last: Tetanus Inj…… Flu Vax:……. Whooping Cough Vax:…….

Would you like to register with My Health here at this practice and upload your summary? Yes ☐ No ☐

Have you received medical attention or counselling for psychological or emotional issues? Yes ☐ No ☐

Have you been prescribed medication for psychological or emotional issues? Yes ☐ No ☐

I certify that the information supplied is true and correct to the best of my knowledge:

Signature: ……**Date:** ……

Please note: Undisclosed information, or inaccuracies in the information provided, could result in an adverse outcome in relation to your medical treatment.