HOSPITAL STREET DOCTORS

New Patient Registration Form

☐Mr ☐Mrs ☐Ms ☐Miss ☐Master ☐Dr Gender ☐Male ☐Female ☐Other ______________________

Surname: ________________________________ First Name: ____

Middle name: ____________________________ Preferred Name: ______________________________________

Date of Birth: ______/_______/______________

Postal address: ____

____ Suburb & Postcode: __________________________________

Home phone: ___________________ Mobile: _______________________ Work: ___________________________

Email address: ____

Emergency contact person: ____

Relationship to patient: ______________________ Contact number: ______________________________________

☐ As above

Next of Kin: _______________________________ Relationship to patient: _________________________________

Contact number: ____

Ethnicity: ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Other _______________________________

Medicare number: ___________________ Card expiry: _______/________ Reference number: __________________

DVA number: _______________________________ DVA card colour: _______________________________________

☐Pension or ☐Centrelink Health Care Card Number: __________________ Card expiry: _____________/__________

MEDICAL INFORMATION

Allergies ☐NIL known

Allergy/Intolerances	Reaction	Severity

Reactions to medications: ____

____

Please list current medications & dosage, including vitamins, minerals & supplements:

____

____

Medical and surgical history: ____

____

LIFESTYLE HEALTH HISTORY (specify approximate month/year)

Smoking history: -
- ☐ Non smoker
- ☐ Former smoker, quit date _______/_____
- ☐ Current smoker: ____________________

Alcohol: -

Do you drink alcohol? ☐yes ☐no

Number of drinks per day ______________

Number per day: _____________________

Mother's Medical History: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Breast Cancer Alive YES/NO

Father's Medical History: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Prostate Cancer Alive YES/NO

Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Live with: ☐Spouse/partner ☐Parent/relative/guardian ☐Friend ☐Alone

If you have a carer, person's name: ____

Carers contact number: ____

Your occupation: ____

Consent:

1. I consent to the use and/or disclosure of my personal health information by the clinic to other health care providers involved in my medical care.
2. I consent/do not consent to my e-health records being uploaded
3. As part of good preventative care, I consent to the clinic sending me reminders and recalls
4. I acknowledge that if I fail to cancel or reschedule an appointment by the close of business the day before I will incur a non-refundable $35 fee.
5.

Signature: ____ Date: _____________/___________/________________