JUNEE MEDICAL CENTRE
98 BROADWAY STREET
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NEW PATIENT REGISTRATION FORM

PERSONAL DETAILS

Title: Mr Mrs Ms Miss Master Other Title: _____

First Name: _____ Middle Name: _____ Surname: _____

Date of Birth _____ / _____ / _____

Birth Gender: Male ☐ Female ☐

Gender Identity: Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Other _____

Pronouns: She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other: _____

CULTURAL IDENTIFICATION

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

☐ Neither ☐ I am part of the Closing the Gap (CTG) Program

Country of Birth: _____ Ethnicity: _____

What is your preferred language if not English? _____ Do you require an interpreter ☐ Yes ☐ No

CONTACT INFORMATION

Address: _____

Town/Suburn: _____ Postcode: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Email: _____

If you have a postal address different from the above, please provide below:

_____

_____

Preferred method of contact for results, recall reminders etc.

☐ Home ☐ Work ☐ Mobile ☐ I consent to SMS communications

BILLING INFORMATION

Medicare Number: _____ Line No _____ Expiry ____/_____

Veteran Affairs No: _____ GOLD ORANGE WHITE Expiry ____/____/_____

Concession Card No: _____ Expiry ____/____/_____

Concession Card Type: Pension- full Pension – part Health Care Card Seniors Card

SOCIAL HISTORY

Current Occupation: _____ OR Retired

Marital Status: _____ OR Prefer not to state

Sexual Preference: _____ OR Prefer not to state

Are you an Elite Athlete: YES NO

NEXT OF KIN / EMERGENCY CONTACT

Next of Kin: _____ Relationship: _____

Address: _____

Contact No: _____

Emergency contact *(if different from next of kin)*

Emergency Contact: _____ Relationship: _____

Address: _____

Contact No: _____

MEDICAL INFORMATION

Medications: Please list any current medications you are taking, including the dosage. Please also include any over the counter products, vitamins and/or supplements you use on a regular basis.

Name:	**Dosage:**
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: Do you have any allergies or are you sensitive to any drugs or dressings? YES NIL KNOWN

If yes what are you allergic to?	Reaction/Symptoms:	Severity?
_____	_____	Mild Moderate Severe
_____	_____	Mild Moderate Severe
_____	_____	Mild Moderate Severe

Current Medical Conditions:

_____

_____

_____

Smoking Status:

I am a ☐ Non Smoker ☐Smoker ☐ Ex-Smoker

If you are a smoker: # per day _____ Year Started _____ Ex-smoker – year quit? _____

Alcohol Intake:

☐ Non drinker (or child) ☐ 1 – 2 days/week ☐ 3 – 4 days/week ☐ 5 – 6 days/week ☐ Everyday

On a day you drink alcohol, how many standard drinks do you have? _____

Are you a carer or does someone care for you? ☐ No ☐ Yes – please state: _____

Do you have an Advanced Care Directive? YES NO UNSURE

Do you have an Enduring Power of Attorney? YES NO UNSURE

FAMILY HISTORY

Please tick where appropriate

	Mother	**Father**	**Sibling**	**Mother's Side of Family**	**Father's Side of Family**
Diabetes					
High Blood Pressure					
Heart Disease					
Stroke					
Colon Cancer					
Depression					
Cancer (please specify type)					

OR: Nil significant Family History: ☐

MANAGEMENT OF PATIENT HEALTH INFORMATION – PRIVACY DISCLOSURE

This practice is bound by the National Privacy Principals. These Principals set the standard by which we handle personal information collected from patients. As part of our commitment to you to provide quality healthcare, personal information is sought from you in order to provide a proper assessment, diagnosis and treatment of a condition for which you are attending our practice. Your personal information may be disclosed to others involved in your healthcare, including other treating doctors and specialists. Your medical file will be handled with the upmost respect for your privacy. If you require a copy of our Practice Privacy Policy, please speak with our Reception team.

PATIENT SIGNATURE & CONSENT

I consent to my personal information being collected and used in accordance with the Centre's Privacy Policy.

By registering with this Practice, I consent to being added to the Recall and Reminder system for the purpose of communicating clinical information and important preventative health reminders.

I understand I am responsible for updating my contact details as my circumstances change (i.e. moving home or changing phone numbers).

Signed _____ Date _____ /_____ /_____