Century Circuit Medical Centre – New Patient Registration Form

Section A: Personal Details

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Master Gender: ☐ Female ☐ Male

Given Name:_____ Surname:_____ Date of birth: _____

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

Medicare Number:_____ Reference Number:_____ Expiry Date:_____

(10 digits on top line of Medicare Card) (Number you are on the card) (bottom right hand corner)

Centrelink Concession card no. **:** _____ Expiry Date**:** _____

Address: _____

Suburb: _____State: _____ Postcode:_____

Mobile Phone: _____ Email: _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Emergency Contact Details

Contact Name: _____ Relationship: _____ Mobile: _____

Next of Kin ☐ As Above

Contact Name: _____ Relationship: _____ Mobile: _____

Section B: Cultural/Social Background & Family History

Knowing your cultural background can help us provide healthcare first meets your individual needs

Are you of Aboriginal or Torres Strait Islander origin? No ☐ Aboriginal ☐ Torres Strait Islander ☐ ATSI ☐

Other cultural background (eg. Mediterranean, Asian, Africa) _____ Country of birth _____

Is English your first language? Yes ☐ No ☐ Please specify language _____

Are you a drinker? No ☐ Yes ☐ _____ standard drinks daily/weekly/monthly

Are you a smoker? No ☐ Yes ☐ _____ cigarettes daily Former smoker ☐

Do you have any family histories? No ☐ Yes ☐ Please specify (eg father diabetes)_____

_____

_____

Section C: Allergies and medicines ☐ No allergies known

List allergies and intolerances to medications	Reaction

List regular medications and doses _____

_____

Signature of Patient: _____Date: _____

Section D: Consent

Our practice uses a reminder system to maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, pap smear and other health reviews. I consent to being contacted with reminders to help me maintain my health - Yes ☐ No ☐

Our practice also sends information to the Department of Human Services' Australian Childhood Immunisation Register, Pap Smear Register and My Health Record system. I consent to immunisations and allergies being sent to Department of Human Services' Australian Childhood Immunisation Register and My Health Record system ☐ Yes ☐ No

Section E: Transfer of health information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place. Please advise us if your contact or information or Medicare details change.