



Appletree Hill Medical Centre

NEW PATIENT REGISTRATION FORM

Admin to complete
Patient details added to file
Date/Initial: _____

Clinical team to complete
Patient details updated in MD
Date/Initial: _____

The information we request assists us in providing you with the highest level of care. Your personal and health information may be disclosed to other providers involved in your health care, and will be disclosed for administrative & billing purposes, including compliance with Medicare and Health Insurance Commission requirements. This form complies with the RACGP Standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with your GP.

Title: Mr Mrs Ms Miss Master Other

First Name: _____ Middle Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: ___/___/___ Gender: _____

Marital Status: Single Married De facto Separated Divorced Widowed

Home Address: _____ Postcode: _____

Postal Address: _____ Postcode: _____
(if different to home address)

Telephone Number: _____ Work: _____ Mobile: _____

Consent to SMS reminder and recalls: Yes No Consent for My Health Record upload: Yes No
Consent to post reminder and recalls: Yes No

Medicare card number: _____ IRN: _____ Expiry: ___/___/___

Pension, HCC, or Veterans Affairs Number (if applicable): _____ Expiry: ___/___/___

Next of Kin

Name: _____ Relationship to you: _____

Telephone Number: _____ Mobile Number: _____

Home Address: _____ Postcode: _____

Who can we contact in an emergency? (if different to Next of Kin)

Name: _____ Relationship to you: _____

Telephone Number: _____ Mobile Number: _____

Home Address: _____ Postcode: _____

Australia is a genuinely multicultural country. Knowing your cultural background & ethnicity can help us tailor appropriate healthcare and assist with health initiatives to meet your individual needs.

Are you Aboriginal or Torres Strait Islander descent? Aboriginal Torres Strait Islander Neither

Country of Birth: _____ Ethnicity: _____ Year of Arrival in Australia: _____

Do you require an interpreter? Yes No If so, what language? _____

To whom should the account be addressed if the patient is a child:

Name: _____ DOB: ___/___/___ Phone: _____

Home Address: _____ Postcode: _____

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Allergies/Adverse Reactions/Warnings:

Do you have any allergies or are you sensitive to medications or dressings? Yes No

Medication, Dressing or substance, food	Reaction (eg: rash, shortness of breath, wheeze, anaphylaxis)

Past Medical History	Current Medications

Smoking History

Smoker Ex Smoker Never Smoked

Frequency: Daily Less than weekly
 Weekly

Number of cigarettes: _____

Year Commenced: _____

Last quit attempt: _____ Unknown

Family History: Have any member of your family been diagnosed with or suffered from (list relationship to you):

- Diabetes _____
- Cancer _____
- Heart Disease _____
- Asthma _____
- Other Conditions _____

Alcohol History

Do you drink alcohol? Yes No Never

How often do you drink alcohol?

- Month or less 2-4x/month
- 2-3x/week 4 or more/week

How many standard drinks with alcohol do you have per day?

- 1 or 2 3 or 4 5 or 6
- 7 to 9 10 or more

How often do you have 6 or more drinks?

- Never Weekly Monthly
- Less than monthly Daily

Are you concerned about your drinking?

- Yes No Don't know

Social/Family History

Who lives at home with you?

Are you a carer for someone? Yes No

Is someone a carer for you? Yes No

Health Check dates:

Last cervical screening test date: _____

Breast check: _____

Mammogram: _____

Prostate (PSA) check: _____

Bone Mineral Density (BMD) Scan: _____

Privacy Consent

I have read the information above and understand the reasons my information must be collected. I am also aware that this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but failure to do so might compromise the quality of health care and treatment I receive.

I am aware of my right to access information collected about me, except in circumstance where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set above, subject to any limitations on access or disclosure that I notify this practice in writing.

Full Name:	Date:
Signature of Patient or Parent/Guardian:	

How did you hear about Appletree Hill Medical Centre:

Website Google Family/Friend Health Engine Others: