

New Patient Registration Form

We need this information to provide the best quality care. 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 concerns, please discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

Title:		Medicare No:	
Family name:		Reference No:	Expiry:
Given Name:		Concession No:	Expiry:
Middle Name:		Concession Type:	
Preferred Name:		DVA No:	
Date of Birth:		DVA Type:	
Gender:		Occupation:	
Ethnicity:			
Address:			
City/Suburb:		Postcode:	
Home Phone:		Work Phone:	
Mobile Phone:		Preferred Contact:	
Email address:			
Next of Kin:		Mobile Phone:	Relationship:
Emergency Contact:		Mobile Phone:	Relationship:
Height:		Weight:	
List Allergies/Intolerances:		Reaction:	Severity:
Are you a Refugee or Asylum Seeker?		Year of Entry:	Country of Origin:

Family/Social History:

Mother:		Age at Death:		Cause of Death:	
Father:		Age at Death:		Cause of Death:	
Mother:					
Father:					
Marital Status:					
Sexuality:		Elite Athlete:			

Current Alcohol Intake:

Days per week:		Standard drinks per day:		Description:	
Past Intake:		Year started:		Year stopped:	

Current Smoking History:

What do you smoke:		Cigarettes/day:		Year started:	
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CONSENT

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews.	I consent to being contacted with reminders to help me maintain my health
Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move.	I consent to being contacted with reminders to help me maintain my health
Deer Park Medical Centre collects medical information for the purpose of medical treatment and may consult with third parties in the interest of your care.	I consent to my medical information being collected and used as required for my health
Deer Park Medical Centre expects payment for services which incur fees on the day they are provided. Any expenses or costs incurred by Deer Park Medical Centre in recovering outstanding monies including debt collection fees will be paid by the parties above.	I understand that Deer Park Medical Centre requires payment on the day of treatment and consent to do so
Signature of patient or guardian:	<div style="background-color: red; width: 400px; height: 20px;"></div>
Date:	

Transfer of health information: You may have 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 information or Medicare details change.

Office Use Only Reception _____ Nurse _____
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