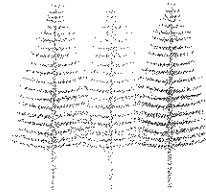


Hatherley Medical Centre

Patient Registration & Information Form



Title: Mr Mrs Miss Ms Dr Other Family Name:

Given Name/s: Preferred Name:

Date of Birth: Occupation:

Address & Postcode:

Mobile No: Home No: Work No:

Email address: Consent for SMS? Yes / No

Medicare No:	Expiry Date:/.....	Ref No:
Pension/HCC No:	Expiry Date:/.....	
Dept of Veteran Affairs No:	Expiry Date:/.....	

Person responsible for payment of account if different from above: (if you are not registered here yourself)

Family name:	Given Name:	DOB:
Address:		
Medicare No:	Expiry Date:/.....	Ref No:

Next of Kin / Emergency Contact: **Please include 2 contacts if possible.**

Name: Relationship: Phone No:

Name: Relationship: Phone No:

Australia is a genuinely multicultural society. For us to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and background, please answer the following:

Do you identify yourself as: (please circle one) Neither Aboriginal Torres Strait Islander Both

What is your Nationality if not Australian:

Are you registered for MY HEALTH RECORD? Yes / No

My Health Record is the name of the national digital health record system. Having a My Health Record means your important information like allergies, medical conditions & treatment, medications, test or scan reports can be digitally available in one place. Healthcare Providers like GP's, Specialists and hospital staff may be able to see it online from anywhere at any time they may need to, like in the case of accident or emergency. Please enquire at Reception for a form or more information.

How did you hear about us? We would like to know!

<input type="radio"/> Previous Patient	<input type="radio"/> Internet	<input type="radio"/> Recommendation
<input type="radio"/> Advertising	<input type="radio"/> Close to home	<input type="radio"/> Other- Please specify:

Hatherley Medical is committed to providing our patients with quality comprehensive health care in a welcoming and professional environment. To help us to give you the best possible care we ask that you please fill in all relevant details where possible. Our practice provides our patients with preventative care and early case detection recalls / reminders e.g. immunisations, pap smears, mammograms, Care Plans etc.

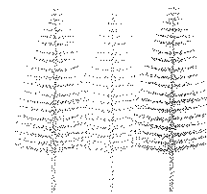
Please advise us if you do not wish to be placed on a recall system. All your personal information is used for the sole purpose of ensuring correct data entry of your details is efficiently entered into our system. At no time will this information be provided to a third party.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We are a Private billing practice and fees must be paid in full at the end of each consultation. We accept payment by Cash, Card & Cheque. Any Medicare rebates can be debited to a Savings/Cheque account immediately, or alternatively sent direct online to Medicare. Pensioners, Health Care Card & Commonwealth Seniors Holders are required to pay a \$30 out of pocket expense once per month, you will then be Bulk Billed for any other appointments within that month. Department of Veteran Affairs Card Holders and Children Under 16 will be Bulk Billed.

Signature of Patient / Guardian	Date:
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Hatherley Medical Centre – Your Health History



Name: Marital status:

Advance Health Directive: Yes No

Enduring Guardian: Yes No

Blood Group (if Known) Height: cms Weight Kgs

Do you have any allergies and / or are you sensitive to any medications or dressings? Yes (please list) No

Do you smoke: Yes – when did you start? How many per day?..... No

If you are an ex-smoker, when did you stop

Do you consume alcohol: Yes No Occasionally - how many standard drinks per day:Week

How often would you exercise or engage in physical activity? Daily Weekly Never

If you are over 50 years of age, have you had a test as part of the National Bowel Cancer Screening Program? Yes No

FEMALES: do you know when you last had a:

Pap Smear: Date:/...../..... Not sure Never

Mammogram / Breast check: Date:/...../..... Not sure Never

FAMILY HISTORY:

Are your parents still alive? Mother Yes No (cause of death)

Father Yes No (cause of death)

Do any of your family members have a history of any of the following:

Depression/Anxiety Yes No Mother/Father
Diabetes Yes No Mother/Father
Stroke Yes No Mother/Father
Heart Disease Yes No Mother/Father
Hypertension: Yes No Mother/Father
Cancer Yes No Mother/Father (please state type of cancer)

ADULT IMMUNISATIONS:

Have you had the following immunisations? (list date if known)

Boosterix	<input type="checkbox"/> Yes. Date:	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Influenza	<input type="checkbox"/> Yes. Date:	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Hepatitis A	<input type="checkbox"/> Yes. Date:	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Hepatitis B	<input type="checkbox"/> Yes. Date:	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Pneumococcal	<input type="checkbox"/> Yes. Date:	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

CHILDRENS IMMUNISATIONS: If completing this form for a child, are their immunisations up to date? Yes No

Signature of Patient / Guardian	Date:
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