HATHERLEY MEDICAL CENTRE

PATIENT REGISTRATION 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? Please state: ……………………………………………………………………………

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

○ Previous Patient	○ Internet	○ Recommendation
○ Advertising	○ Close to home	○ 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 Affair Card Holders and Children Under 16 will be Bulk Billed.

Signature of Patient / Guardian	**Date:**

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) …………………………………… Age at Death: ………………………

Father ◯ Yes ◯ No (cause of death) …………………………………… Age at 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	☐ Yes. Date:	☐ No	☐ Don't Know
Influenza	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis A	☐ Yes. Date:	☐ No	☐ Don't Know
Hepatitis B	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ 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:**