HATHERLEY MEDICAL CENTRE - PATIENT REGISTRATION FORM

Hatherley Medical is committed to providing our patients with quality comprehensive health care in a welcoming and professional environment.

Title: ..... Gender: ..... Family Name: .....

Given Name/s: ..... Preferred Name: .....

Date of Birth: ..... Occupation: .....

Residential address: .....

Postal address if different from above: .....

Postcode: ..... Email address: .....

Home / Work No: ..... Mobile No: ..... Consent to SMS? Yes / No

SMS may be used to notify you of upcoming appointments with the practice which allows you to confirm your appt. YOU CANNOT CANCEL APPT WITH SMS REPLY. Clinical reminders and communications regarding follow up appointments for immunisations, mammograms, cervical screenings, care plans etc and request to follow up test results may also be communicated via SMS.

Medicare Card No: ..... Expiry Date: ...../..... Your Ref No: .....

Pensioner / Health Care / Commonwealth Seniors cards. No: ..... Expiry Date: ...../.....

Dept of Veteran Affairs No: ..... Expiry Date: ...../..... Gold / White

Identification - All patients to provide identification. Type of identification: Medicare card / Other

Administration use only – identification sighted. Administration Signature: .....

Next of Kin

Full Name: ..... Relationship to you: ..... Phone: .....

Emergency contact

Full Name: ..... Relationship to you: ..... Phone: .....

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:

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: …….

Patient Consent and Declaration

Please read below information prior to signing. A copy of our privacy policy, which includes information about the collection, use and disclosure of your health information can be requested from reception.

- I acknowledge that Hatherley Medical Centre is a Private Billing practice and that fees are to be paid on the day of consultation.
- I acknowledge that Hatherley Medical Centre has a policy for patients who DO NOT ATTEND booked appointments and late cancellations and that a fee of $45.00 may incur.
- I have read the Patient Consent and Privacy document and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed.
- I give permission for my personal information to be collected, recorded, and disclosed for the purpose of receiving the best possible medical treatment, to send referrals to specialists, hospitals, or other health providers. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken, I also understand that I am free to withdraw my consent at any time by notifying the practice in writing.
- I confirm that all the details provided are correct and true.

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: **Cervical Screening:** Date: ……/……/…… Not sure / Never

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

FAMILY HISTORY: **Are your parents still alive?**

Mother ◯ Yes ◯ No (**cause of death if known**) …… Age of Death: ……

Father ◯ Yes ◯ No (**cause of death if known**) …….. Age at Death: ……..

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

Depression/Anxiety. ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other
Diabetes. ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other
Stroke. ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other
Heart Disease. ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other
Hypertension. ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other
Colon Cancer – ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other
Breast Cancer – ◯ **Yes** ◯ **No** Mother / Father / Sibling / Grandmother / Grandfather / Other

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 or B (please circle)	☐ Yes. Date:	☐ No	☐ Don't Know
COVID Vaccinations	☐ Yes. Date:	☐ No	☐ Don't Know
Pneumococcal	☐ Yes. Date:	☐ No	☐ Don't Know
Shingrix or Zostavax (Shingles vaccine)	☐ 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:**