



# NEW PATIENT REGISTRATION FORM (ADULT)

Bridging Healthcare Pty Ltd

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We need this information to provide the best quality care. This form complies with the RACGP *Standards for General Practices (5<sup>th</sup> ed)*, meaning your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your nurse practitioner.

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.

## SECTION A: PERSONAL DETAILS

Title	Surname	Given Names	
Preferred Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Non-Binary	
Address		City/Suburb	
Postcode	<input type="checkbox"/> Mobile	<input type="checkbox"/> Home	<input type="checkbox"/> Work
Email		Occupation	
Medicare Card Number □ □ □ □ □ □ □ □ / □		Pension Card Type/Number □ □ □ □ □ □ □ □ □ □	
Expiry □ □ / □ □ □ □		Expiry □ □ / □ □ □ □	

## NEXT OF KIN

Name	Relationship
Best Contact Number: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> This person is also my emergency contact.

## WHO CAN WE CONTACT IN AN EMERGENCY?

Name	Relationship
Best Contact Number: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Same contact as above.

Do you have an advance care directive for end of life care?  Yes  No  I would like more information about this.

### Do you want us to upload relevant information to your MyHealth Record?

Yes – with my consent.  No  I would like more information about this.

### Do you want us to upload any vaccinations you receive to the Australian Immunisation Register?

Yes – with my consent.  No  I would like more information about this.

### How did you hear about us?

Google  Facebook  Pharmacy Staff  Friend/Family  Friend/Family  Signage  
 Other \_\_\_\_\_

## SECTION B: CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

### Are you of Aboriginal and/or Torres Strait Islander origin?

No  Aboriginal  Torres Strait Islander  Prefer not to say

<b>Other cultural background</b> (e.g. Mediterranean, Asian, African)	<b>Country of Birth</b>
<b>Is English your first language?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Language(s) spoken at home:</b>
<b>Do you require an interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION C: ALLERGIES AND MEDICINES

List any allergies to medicines or intolerances that you have:	Describe your reaction:
<input type="checkbox"/> I have no known allergies to medicines.	
<b>List any regular medicines you take, along with doses (if known). Include herbal or vitamin products.</b>	
<input type="checkbox"/> I do not take any regular medicines.	

## SECTION D: MEDICAL HISTORY

Please tick any relevant *personal* past medical/surgical history.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Blood Clots                | <input type="checkbox"/> Mental Health Issue |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Asthma, COPD or Emphysaema |  |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Acid Reflux                |  |

## SECTION E: LIFESTYLE HISTORY

Smoking:

Never smoked  Smoker \_\_\_\_\_/day; started what age? \_\_\_\_\_  Former smoker, quit date \_\_\_\_\_

Alcohol:

Non-drinker  Drinker; Average Number of Days/Week \_\_\_\_\_ Average Number of Drinks/Occasion \_\_\_\_\_

## SECTION F: CONSENT

Bridging Healthcare uses a reminder system to help you maintain your health. The clinic sends reminders by email, post or SMS for reminder procedures like vaccinations and other health reviews you need. By signing below, you consent to being contacted for reminders relating to the planning and managing of your health. By signing below you consent to your de-identified health information to be shared for the purposes of service improvement and research activities that provide insight into and improve community health and health services management.

Patient Name (Printed) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_