NEW PATIENT REGISTRATION FORM (ADULT)

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We need this information to provide the best quality care. This form complies with the RACGP *Standards for General Practices (5th 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** ☐ Male ☐ Female ☐ Intersex ☐ Non-Binary
Address		**City/Suburb**
Postcode	☐ **Mobile**	☐ **Home** ☐ **Work**
Email		**Occupation**
Medicare Card Number ☐☐☐☐☐☐☐☐☐☐ / ☐ **Expiry** ☐☐ / ☐☐☐☐		**Pension Card Type/Number** ☐☐☐ ☐☐☐ ☐☐☐ ☐ **Expiry** ☐☐ / ☐☐☐☐ **Type?**

NEXT OF KIN

Name	**Relationship**
Best Contact Number: ☐ **Mobile** ☐ **Home** ☐ **Work**	☐ This person is also my emergency contact.

WHO CAN WE CONTACT IN AN EMERGENCY?

Name	**Relationship**
Best Contact Number: ☐ **Mobile** ☐ **Home** ☐ **Work**	

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______________________

- Please Complete Other Side of this Form -

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

Other cultural background (e.g. Mediterranean, Asian, African)	**Country of Birth**
Is English your first language? ☐ Yes ☐ No	**Language(s) spoken at home:**
Do you require an interpreter? ☐ Yes ☐ No	

SECTION C: ALLERGIES AND MEDICINES

List any allergies to medicines or intolerances that you have:	Describe your reaction:
☐ I have no known allergies to medicines.	

List any regular medicines you take, along with doses (if known). Include herbal or vitamin products.
☐ I do not take any regular medicines.

SECTION D: MEDICAL HISTORY

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

☐ Heart Problems
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes
☐ Cancer
☐ Migraines
☐ Stroke
☐ Blood Clots
☐ Asthma, COPD or Emphysaema
☐ Acid Reflux
☐ Ulcers
☐ Epilepsy
☐ Mental Health Issue

SECTION E: LIFESTYLE HISTORY

Smoking:

☐ Never smoked ☐ Former smoker (quit date)____________ ☐ Smoker____________/day; started what year?_________

Alcohol:

☐ Non-drinker ☐ Drinker

Average Number of Days/Week you have a drink___________ 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**__________