GOOLWA MEDICAL CENTRE - PATIENT REGISTRATION FORM

CONTACT INFORMATION:

TITLE: Mr / Mrs / Miss / Ms / Other: _________________ **GENDER:** Male / Female / Other: _________________

SURNAME: ____________________________ **FIRST NAME/MIDDLE NAME:** _______________________________

ADDRESS: ____

POSTAL ADDRESS (if different): ____

DATE OF BIRTH: ________________________ **OCCUPATION:** ____

HOME PHONE: ________________________ **MOBILE:** _____________________ **WORK:** ____________________

EMAIL ADDRESS: ____

Do you consent to receiving text message reminders on your mobile phone: Yes / No

Do you consent to your personal information being released to third parties if required to do so by email (ie referrals, medical summaries: Yes / No (please note an email is classed as being at High Risk and not completely confidential in nature. Every effort is made to keep your information as private and confidential as possible when sending an email)

EMERGENCY CONTACT DETAILS:

NAME: ____ **PHONE NO:** ___________________________________

RELATIONSHIP TO YOU: ____

NEXT OF KIN: ____________________________________ **PHONE NO:** ___________________________________

RELATIONSHIP TO YOU: ____

HEALTHCARE IDENTIFIERS:

MEDICARE NO: ____ **REF NO:** ______ **EXPIRY DATE:** _______________

PENSION CARD NO: ___________________________ **EXPIRY DATE:** ______________________________

HEALTH CARE CARD NO: ________________________ **EXPIRY DATE:** ______________________________

DVA FILE NUMBER: ____________________________ **EXPIRY DATE:** _______________________ **GOLD / WHITE**

CULTURAL IDENTITY

To Assist with health initiatives – could you please tell us if you identify as: ☐ No

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

Were you born outside of Australia? ☐ No ☐ Yes

(If yes, which country were you born in)_________________________ Do you require an interpreter? ____________

YOUR HEALTH INFORMATION:

Allergies/Warnings – do you have any allergies or are you sensitive to any drugs & dressings?

☐ Yes (please provide details below) ☐ No

____

____

Current Medications: Please list all your current medications, including complementary and over the counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc)

____

____

Medical History: Do you have or have you had a history of the following:

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Surgery (provide details)

☐ Other: ____

LIFESTYLE RISK FACTOR INFORMATION:

Smoking ☐ Yes (how many) _______ day _______ week ☐ No

Alcohol ☐ Yes (how many) ________ day _______ week ☐ No

Recreational Drug Use ☐ Yes – Type______________ Frequency ☐ No

FAMILY HEALTH HISTORY INFORMATION:

Have any members of your family have any of the following ailments:

☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Hypertension

☐ Mental Illness ☐ Cancer – type: ____

☐ Other significant – provide details: ____

Do you have Private Health Insurance ☐ Yes ☐ No Name of Provider: ___________________________________

PLEASE NOTE:

Goolwa Medical Centre is not a bulk billing practice; however, a doctor may use their discretion in cases of genuine financial hardship and chronically ill patients in need of frequent medical attention.

Gaps Payable are: $20.00 Pension/Health Care Card $30.00 Patients with no concession

Please Note: Appointment times are 10 minutes per patient. If you require a longer time for your appointment, please let our reception staff know when making your appointment.