New Patient Registration Form

We wish to acknowledge the Traditional Owners of the land where we work and live. We pay respect to Elder's past, present and emerging.

We require this information to provide the best quality care. This form complies with the RACGP *Standards for general practices.* Thi s means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please discuss with your GP.

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.

Personal Details

Title _____ Surname _____ Given Name _____ Preferred Name _____

Date of Birth _____ Birth Sex _____ Gender _____ Pronouns _____

Marital Status □ Single□ Married □ Defacto □ Separated □ Divorced □ Widowed

Medicare Card Number_____ Reference Number _____ Expiry Date _____

Pension, Health Care, or DVA number _____ Type _____ Expiry Date _____

Marital Status _____ Occupation _____

Home Address _____ Postcode _____

Postal Address _____ Postcode _____

Telephone Number _____ Work Number _____ Mobile Number _____

Email _____

Next of Kin Name _____Phone Number _____ Relationship _____

Emergency Contact Name _____ Phone Number _____ Relationship_____

Do you have an advance health directive for end of life care? □ Yes □ No

For more information talk to your GP.

Cultural background

Are you of Aboriginal or Torres Strait Islander origin?

□ No □ Yes, Aboriginal □ Yes, Torres Strait Islander □ Yes, both Aboriginal and Torres Strait Islander

Ethnicity: _____ Country of Birth: _____

Is English your first language? □ Yes □ No

If not, do you require an interpreter? □ Yes □ No Language: _____

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Family history

□ Unknown (e.g. Adopted) □ No significant family history

Mother alive? □ Yes □ No Age at death: _____ Cause of death: _____

Father alive? □ Yes □ No Age at death: _____ Cause of death: _____

Significant family history:

Mother: □ Diabetes □ Hypertension □ Heart disease □ Stroke

□ Colon cancer □ Breast cancer □ Depression

Father: □ Diabetes □ Hypertension □ Heart disease □ Stroke

□ Colon cancer □ Prostate cancer □ Depression

Medical history

Height _____ Weight _____

Alcohol intake:

□ Non-drinker Days per week _____ Standard drinks per day _____

Smoking status:

□ Non-smoker □ Ex-smoker □ Current smoker

Cigarettes per day _____ Year started _____

Allergies/Adverse Reactions:

Medical Condition(s):

Regular Medications and Doses:

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Consent

Our Practice uses a reminder system to help maintain your health. The reminders are sent by post, telephone, or SMS.

I consent to being contacted with reminders. □ Yes □ No

Our Practice sends information to the National Cancer Screening Register (e.g. Cervical Cancer and Bowel Cancer Screening Registers). These registers also send reminders, which can be helpful if you move.

I consent to my information being sent to these registers. □ Yes □ No

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Our Practice also sends information to My Health Record. My Health Record allows your healthcare provider to upload or access important information, such as allergies, medical conditions, blood test/imaging results, hospital discharge summaries, and your immunisation history.

I consent to my information being sent to My Health Record. □ Yes □ No

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Fees

Kincraig Medical Clinic is a private billing practice and full payment on the day is required. All patients, including health care card holders, will be required to pay a gap or out of pocket cost for all appointments.
Pension Card holders will be bulk billed for standard consults however, a gap will apply for other appointment types.
You must present your pension card at each visit.
If you have registered your bank details with Medicare, you will receive your Medicare rebate back into your account within 24-48 hours.
Our fees are set in line with the recommendations of the Australian Medical Association.

_____ _____

Patient/Guardian Signature Date