

# New patient registration form

Please print letters  
Use black or blue pen  
Place ✓ in all applicable boxes

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. This means 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 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.

## Practice name

## Section A: Personal details

Title	Surname	Given names
<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of birth (dd/mm/yy)	Gender	Marital status
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Medicare card number	Medicare reference number	Medicare card expiry date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>

Pension, Health Care Card, or Veterans Affairs number (if applicable)	Type of Veterans Affairs card	Expiry date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/>

Occupation

Home address	Postcode
<input type="text"/>	<input type="text"/>

Postal address	Postcode
<input type="text"/>	<input type="text"/>

Telephone number	Work number	Mobile number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email

## Who can we contact in an emergency?

Name	Relationship to you
<input type="text"/>	<input type="text"/>

Telephone number	Work number	Mobile number
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Do you have an advance health directive for end of life care?

Yes  No

For more information talk to your GP.

## Section B: Cultural background

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

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

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

Other cultural background (eg Mediterranean, Asian, African)

Country of birth

Is English your first language?

If not, do you require an interpreter?

Please specify language

Yes     No

Yes     No

## Section C: Allergies and medicines

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### List allergies and intolerances to medications

### Describe your reaction

### List regular medications and doses, and complementary medicines and doses

## Section D: Consent

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Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews.

### I consent to being contacted with reminders to help me maintain my health

Yes     No

Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move.

### I consent to being contacted with reminders to help me maintain my health

Yes     No

Signature of patient or guardian

Date

 /  / 

## Section E: Transfer of health information

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You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

**Please advise us if your contact information or Medicare details change.**