



New Patient Registration Form

Filling in this form: Please print in **BLOCK LETTERS** Mark boxes with ✓ or ✗ Return the completed form to the front desk

Surname:		First Name:		Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Mast <input type="checkbox"/> Dr <input type="checkbox"/>	
Middle Name (if any):			Have you been known previously under another name?		
Preferred Name:			No <input type="checkbox"/> Yes <input type="checkbox"/> (Details): please specify		
Date of Birth: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> (please specify)			
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> De facto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>					
Residential Address		Street Address:			State:
		Suburb:			Postcode: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Postal Address: (if different to the Residential Address above)					
Phone: Home:			Mobile:		
Email: @					
Occupation:			Employer (if applicable)		
Medicare Card Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Ref No <input type="checkbox"/>	Expiry Date: <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
Concession Card Type (if applicable) <input type="checkbox"/> Pension <input type="checkbox"/> Health Care Card		Concession Card Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Expiry Date: <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
DVA Card (if applicable) DVA Card Type: Gold <input type="checkbox"/> White <input type="checkbox"/>		DVA Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Expiry Date: <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
Next of Kin (who would be the best contact person in an emergency?)					
Name:		Relationship to You:		Mobile:	
				Home Phone:	
Email: @					
Cultural Background (knowing your cultural background can help us provide healthcare that meets your individual needs)					
Do you identify yourself as: Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander <input type="checkbox"/> Neither <input type="checkbox"/>					
Is English your first language?		Yes <input type="checkbox"/> No <input type="checkbox"/>		If No, specify your language: Do you require an interpreter? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Smoking Status:		<input type="checkbox"/> Never smoked		<input type="checkbox"/> Current smoker <input type="checkbox"/> Ex-smoker (Year Quit:) <input type="checkbox"/> Not Applicable	
Alcohol intake:		<input type="checkbox"/> I do not drink		<input type="checkbox"/> I drink () drinks per week (in average) <input type="checkbox"/> Not Applicable	
Allergies: (Drugs, food etc)					
Guardian Contact Details (Must be completed if a patient is under 16 years of age)					
Name:		Relationship to patient:			
Phone:		Mobile:		Home:	
Email: @					
Postal Address:		Street Address:		Suburb:	
		State:		Postcode: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Privacy Agreement & Patient Consent					
Promenade Medical Centre (PMC) is committed to protecting your privacy under the Privacy Act (1988). We will collect, store, use and disclose your information necessary to provide quality medical care to you. Such necessary information may include your personal details, identification and contact details, full medical history, family and employment history, billing/account details, Medicare and private health fund details. With your consent, PMC, its staff and authorised representatives may use and disclose your information for purposes such as billing and administrative purposes including compliance with Medicare Australia, referral to other care providers, referral for medical tests and in the reports and results returned to us following these referrals, inclusion in the State and National health registers and reminder systems, and to contact you via SMS, phone or mail for the purpose of Recalls and Reminders. You are entitled to access your health records at any time (conditions apply). To access our full Privacy Policy please ask our staff or visit our website www.promenademedical.com.au . By signing this form, you confirm you have read and understood this Privacy Agreement, and you consent for the Promenade Medical Centre to collect, store, use and disclose your information as outlined in our Privacy Policy.					
Print Name:					
Signed by Patient (or Guardian):				Date: dd / mm / yy	