



## New Patient Registration Form

Filling in this form: Please print in <b>BLOCK LETTERS</b> Mark boxes <input type="checkbox"/> with ✓ or ✗ <i>Return the completed form to the front desk</i>					
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: / /		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:		State:	
		Suburb:		Postcode:	
Postal Address: (if different to the Residential Address above)					
Phone: Home:			Mobile:		
Email: @					
Occupation:			Employer (if applicable)		
<b>Medicare Card No</b>		Ref No <input type="checkbox"/>		Expiry Date: <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/>	
<b>Concession Card Type</b> (if applicable) <input type="checkbox"/> Pension <input type="checkbox"/> Health Care Card		Concession Card Number		Expiry Date: / /	
<b>DVA Card</b> (if applicable) DVA Card Type: Gold <input type="checkbox"/> White <input type="checkbox"/>		DVA No:		Expiry Date: / /	
<b>Next of Kin</b> (who would be the best contact person in an emergency?)					
Name:		Relationship to You:		Mobile:	
Email: @				Home Phone:	
<b>Cultural Background</b> (knowing your cultural background can help us provide health care that meets your individual needs)					
Do you identify yourself as? Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Non-Indigenous Australian <input type="checkbox"/> Other <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"/>	
<b>Smoking Status:</b>		<input type="checkbox"/> Never smoked		<input type="checkbox"/> Current smoker <input type="checkbox"/> Ex-smoker (year quit: ) <input type="checkbox"/> Not Applicable	
<b>Alcohol intake:</b>		<input type="checkbox"/> I do not drink		<input type="checkbox"/> I drink ( ) drinks per day (in average) <input type="checkbox"/> Not Applicable	
<b>Allergies:</b> (Drugs, food etc)					
<b>Guardian Contact Details</b> (Must be completed if a patient is under 16 years of age)					
Name:		Relationship to patient:			
Phone: Mobile:		Home:			
Email: @					
Postal Address: Street:		Suburb:		State: Postcode:	
<b>Privacy Agreement &amp; Patient Consent</b>					
Promenade Medical Centre (PMC) is committed to protecting your privacy under the Privacy Act (1988). With your permission, we will collect, store, use and disclose your information necessary to provide quality medical care to you. Such information may include your 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 and affiliates may use and disclose your information for purposes such as account management, compliance with Medicare Australia and referral to other health care providers. PMC may be required to use your information to update the State and National health registers and reminder systems. PMC may contact you via SMS or phone to notify you of Appointments, Recalls and Reminders. PMC requires that sensitive information (e.g. test results) only be communicated face-to-face by a medical practitioner or qualified health professional. 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 [ <a href="http://www.promenademedical.com.au">www.promenademedical.com.au</a> ]. By signing this form, you confirm you have read and understood this Privacy Agreement, and you consent for PMC to collect, store, and use your information as outlined in our Privacy Policy.					
Print Name:					
Signed by Patient (or Guardian):				Date: / /	