RACGP
Royal Australian College *of* General Practitioners

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**

Date of birth (dd/mm/yy) / / **Gender**

Marital status Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐

Medicare card number **Medicare reference number** **Medicare card expiry date** / /

Pension, Health Care Card, or Veterans Affairs number (if applicable) **Type of Veterans Affairs card** **Expiry date** / /

Occupation

Home address Postcode

Postal address Postcode

Telephone number Work number Mobile number

Email

Who can we contact in an emergency?

Name Relationship to you

Telephone number Work number Mobile number

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

Yes ☐ No ☐

For more information talk to your GP.

4699

Section B: Cultural background

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?

Yes ☐ No ☐

If not, do you require an interpreter?

Yes ☐ No ☐

Please specify language

Section C: Allergies and medicines

List allergies and intolerances to medications

Describe your reaction

List regular medications and doses, and complementary medicines and doses

Section D: Consent

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

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.

The Western Medical Centre

NEW PATIENT FORM

Patient name: ______________________________

Date of birth: ____________________

Please complete the following information and hand the form to your doctor.

Past History including operations. (Please include date and treatment if relevant)
For example asthma, heart disease, cholesterol, blood pressure, diabetes, arthritis, cancer, epilepsy, osteoporosis, etc.
Operations for example appendix, tonsils, gallbladder, joint procedures, skin cancers etc.

Family History (For example Mother, Father, Siblings, Grandparents)
For example asthma, heart disease, cholesterol, blood pressure, stroke, cancer, diabetes, arthritis, epilepsy, osteoporosis etc

Immunisation
Are your immunisations up to date?

Do you exercise regularly? YES / NO

What exercise do you do and how often?

Adult patients only:

Have you ever or do you currently smoke YES / NO
If YES: How many cigarettes do / did you smoke per day? ________
What year did you start smoking? ______
If now an EX-smoker what year did you QUIT?

How often do you drink alcohol?

☐ Never ☐ Less than monthly ☐ 1-2 days per month
☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Daily

When you drink alcohol how many standard drinks do you usually have? ☐

How often do you have more than 6 standard drinks per day?

☐ Never ☐ Less than monthly ☐ 1-2 days per month
☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Daily

Female Adult patients only:

Last pap smear / cervical screening

Last mammogram (If over 50 years of age)