MERRIFIELD CITY MEDICAL CENTRE

New Patient Registration Form

[Please write in CAPITAL LETTERS]

Title : _____ **First Name** : _____ **Last Name** : _____

Middle Names : _____

Date of Birth : DD / MM / YYYY **Birth Sex** : | Female | Male | Other | Unknown |

Gender Identity : | Female | Male |Non-binary | Gender Diverse | Transgender | Different Identity : _____

Pronouns : | He/Him/His | She/Her/Hers | They/Them/Theirs |

Ethnicity: | Australian, non-Indigenous | Aboriginal but not Torres Strait Islander | Torres Strait Islander but not Aboriginal |

| Both Aboriginal and Torres Strait Islander | Other : _____

Medicare No : _____ **IRN** : _____ **Expire Date**: MM / YYYY

Pension / Health Care Card Number : _____ **Expire Date**: DD / MM / YYYY

Pension Card Type : | Pensioner Concession Card | Health Care Card | Commonwealth Seniors Health Card |

DVA Number : _____ **Color** : _____ **Conditions** : _____

Occupation : _____ **Employer** : _____

Home Address : _____

Suburb: _____ **Post Code**: _____

Postal Address : _____ **Post Code**: _____

Email : _____ **Mobile** : _____

Next of Kin [Same as Emergency Contact ◯]	**Emergency Contact [Same as Next to Kin ◯]**
Name: _____	Name: _____
Address : _____	Address : _____
_____	_____
Mobile Number : _____	Mobile Number : _____
Relationship to you: _____	Relationship to you: _____

Continue to next page please.....

Allergies to medication or food : ◯ Yes ◯ No ◯ Unknown

If Yes, please specify allergies : _____

Type of Allergic Reaction : _____

Smoker Status : ◯ Never Smoked ◯ Ex-Smoker : Year Quit _____ ◯ Smoker : _____per day

Alcohol Intake : ◯ Nil ◯ Yes _____ standard drinks per (Tick) ◯ Week ◯ Month

Recreational Drugs : ◯ No ◯ Yes : _____

Regular Medication : ◯ Nil ◯ Yes – Please list any medication and their doses – include over the counter medication and supplements too :

Current/Previous Medical Conditions : ◯ Nil ◯ Yes – Please tick any that apply :

Asthma	DVT	HIV/AIDS	Diabetes Type 1 / Type 2
Emphysema	Hepatitis A / B / C	Heart Attack (MI)	Depression and/or Anxiety
Epilepsy	Stroke / CVA	Pacemaker	Cancer (type)
Any Other :			

Family Medical History : ◯ Insignificant ◯ Yes – Please list Below :

Relationship (eg: Father, Mother, sibling etc)	Condition/s

Our Practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed and uploaded to my eHealth Record as a part of the quality improvement activities in this practice. ◯ Yes ◯ No

I give permission for my personal information being collected, used and disclosed as described in this practice policy. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter and or restrict my consent at any time by notifying this practice in writing : ◯ Yes ◯ No

Our practice uses a reminder system to improve the quality of your health care. This practice sends reminders by mail and/or telephone for procedure such as vaccinations, pap smears and other health reviews.

I consent to being contacted with reminder by SMS/phone/email : ◯ Yes ◯ No

Signature of the patient or guardian : _____ Date : DD / MM / YYYY