Patient Registration & Information Form :

We are committed to providing our patients with the best care.
To do this it is essential that your health record is kept up to date and accurate.

PART A: ALL patients are asked to complete the following.

Title:	☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Other:**
Surname:	
First Name:	**Middle Initial:**
Preferred Name:	**Date of Birth: / /**
Street Address:	
Postal Address: **(if different to street address)**	

☐ **Mobile Phone:**	☐ **Work Phone:**	☐ **Home Phone:**	
Email:			
Occupation:			
Medicare Number:	**Ref No:**	**Expiry Date**	
DVA Gold / White:		**Expiry Date**	
Pension/HCC Number:		**Expiry Date**	
Next of Kin: (Name, Address & Telephone number) **Relationship to Patient**			
Emergency Contact: *(If different to Next of Kin)*	(Name and Telephone number of the person we can contact if needed)		
Sexuality *(optional)*	☐ Heterosexual ☐ Homosexual ☐ Bisexual		

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please elaborate……

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Do you have any allergies or are you sensitive to drugs or dressings? ☐ Yes (please list below) ☐ No

……

Are you an Interstate or Overseas visitor to Melbourne ? ☐ Yes ☐ No

Do you intend to have ongoing medical care provided by Collins Street Medical Centre? ☐ **Yes** ☐ **No**

If **Yes** - please **complete PART B** questions on pages 2,3,4.

If **NO** - please sign below and return to reception.

Signature: …… **Date: ..... / ..... / .....**

I confirm there is no other information that I am aware of that would influence the medical treatment /advice to be provided.

Office Use Only. UR No:_____ Dr: _____ Staff: _____ Nurse: _____

PART B: **Patients who will be continuing to use Collins Street Medical Centres are asked to complete the following.**

Reminder Systems:

Would you like to have appointment reminders sent via SMS?	☐ **Yes**	☐ **No**

Our practice provides our patients with preventive care and early case detection reminders
e.g.: - immunisations, annual health checks; skin checks and pap smears.
***Please note that we do not send "junk mail".*

Do you offer consent to participate? ☐ Yes – mail ☐ No

If No, do you consent to RESULTS being mailed to your home or postal address? ☐ Yes (mail) ☐ No

Your health history: do you have or have you had a history of ?

☐ Operations:	Details: _____	Date: _____
	Details: _____	Date: _____
	Details: _____	Date: _____
	Details: _____	Date: _____
☐ Asthma:	☐ Yes ☐ No	
☐ Diabetes:	☐ Yes ☐ No	
☐ Hypertension	☐ Yes ☐ No	
☐ Chronic illness	☐ Yes ☐ No	
☐ Other		

Immunisations - have you had the following immunisations?

Tetanus booster	Date: _____	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date: _____	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date: _____	☐ Don't Know	☐ Haven't had one
Influenza	Date: _____	☐ Don't Know	☐ Haven't had one
Pneumococcal	Date: _____	☐ Don't Know	☐ Haven't had one
Polio	Date: _____	☐ Don't Know	☐ Haven't had one
Gardasil , 1	Date: _____	☐ Don't Know	☐ Haven't had one
Gardasil , 2	Date: _____	☐ Don't Know	☐ Haven't had one
Gardasil , 3	Date: _____	☐ Don't Know	☐ Haven't had one

Children's immunisations -

If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Current medications (including over the counter medications, vitamins and minerals):

_____

_____

_____

_____

_____

Family history - have any members of your family been diagnosed with or suffered from :

☐ Diabetes: _____

☐ Asthma: _____

☐ Heart Disease: _____

☐ Mental illness: _____

☐ Cancer: _____

Social history:

☐ Tobacco: I have never smoked

☐ Tobacco: Ceased Smoking: ____ / ____ / ____ or _____ per day / week

☐ Alcohol: I do not drink alcohol

☐ Alcohol: _____ days per week _____drinks per day

☐ Alcohol: _____ drinks per week / month

☐ Alcohol: How often would you drink more than 6 drinks per day? _____

☐ Recreational Drug use: _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs **Waist Measurement:** _____ cms

Blood Pressure: ____ **/** ____ When was the last time your blood pressure was taken? ___ **/** ___ **/** ____

How often do you exercise or engage in physical activity for 30 minutes or more?

☐ Daily ☐ _____ times per Week ☐ Never ☐ Other: _____

Females: When did you last have a -

Pap smear	Date_____	☐ not sure	☐ never
Breast Check	Date_____	☐ not sure	☐ never
Mammogram	Date_____	☐ not sure	☐ never

Males: When did you last have a -

An overall check up	Date _____	☐ not sure	☐ never

For those 65 years and older: when was the last time you were immunised for -

Influenza	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia	Date_____	☐ not sure	☐ never

_____

Is there any other information that you believe we should know that may affect / or have an influence on the medical treatment / advice you will be provided with?

If **Yes**, please provide details below -

_____

_____

_____

_____

Signature: …….....…. **Date: ..... / ..... / .....**

Thank you for your cooperation &
please return your completed from to reception.

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