WILLETTON MEDICAL CENTRE
4 Castlereagh Close Willetton WA 6155
T : 9310 1234 F : 9332 2416

NEW PATIENT REGISTRATION FORM

PATIENT DETAILS *[please note (*) are mandatory fields]*

* Title _____ * Surname _____ * Given Name _____

* Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ * Gender ☐ Male ☐ Female

Country of Birth _____ Religion _____ Languages other than English _____

Occupation _____ Place of Employment _____

* Marital Status ☐ Married ☐ Single ☐ De Facto ☐ Separated ☐ Divorced ☐ Widowed

* Medicare No. ☐☐☐☐ ☐☐☐☐☐☐ Ref No. ☐ Expiry Date ☐☐ / ☐☐

☐ Pension ☐ Health Care ☐ Vet Affairs Card No. ☐☐☐☐☐☐☐☐☐☐ Expiry Date _____

* Are you of Aboriginal or Torres Strait Islander Origin ? ☐ Yes ☐ No

If **YES**, please state whether ☐ Aboriginal ☐ Torres Strait Islander ☐ ATSI

CONTACT DETAILS *[please note (*) are mandatory fields]*

* Home Address _____

Postal Address _____

* Contact Numbers Home _____ Work _____ Mobile _____

Email Address _____

NEXT OF KIN & EMERGENCY CONTACT DETAILS *[please note (*) are mandatory fields]*

Next Kin *(family member)*

* Title _____ * Surname _____ * Given Name _____

* Contact Numbers Home _____ Work _____ Mobile _____

* Relationship to patient _____

Emergency Contact *(person whom we may contact in case of an emergency, not living with you, other than your next of kin)*

* Title _____ * Surname _____ * Given Name _____

* Contact Numbers Home _____ Work _____ Mobile _____

* Relationship to patient _____

- I consent to my health record being reviewed as a part of the quality improvement activities at this practice.
- I consent to being contacted with reminders as part of the quality improvement activities at this practice.
- I consent to a third party (interpreter / carer or relative / medical or allied or nursing student / GP registrar) to be present during consult.
- I consent to my doctor sharing requested clinical information with a third party (carer / insurance company / cervical registry / breast screen) where medically relevant.

* Signature _____ Date _____

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MEDICAL / CLINICAL DETAILS

1 Do you have any allergies / intolerences ? ☐ Yes ☐ No ☐ Not Sure

If **YES**, please state allergies _____ Type of Reaction _____

2 Have you been diagnosed with any medical conditions ? ☐ Yes ☐ No

If **YES**, please provide details and year of diagnosis

_____

_____

_____

3 Are you on regular medications ? ☐ Yes ☐ No

If **YES**, please provide medication name and dosage

_____

_____

_____

4 Are you on complementary medications and / or treatment (ex. Accupuncture / Reiki / Herbal / Ayurvedic etc) ? ☐ Yes ☐ No

If **YES**, please provide details

_____

_____

5 Is there any relevant family history of Asthma / Diabetes / Cancer ? ☐ Yes ☐ No

If **YES**, please provide details

_____

_____

6 Social History

a) Are you a migrant to Australia ? ☐ Yes ☐ No

If YES, please state the year of migration _____

b) Who do you live with ? ☐ Spouse / Partner ☐ Parents ☐ Others, please specify _____

c) Highest level of Education / Qualification _____

7 Health Risk Factors

a) Smoking Status ☐ Non smoker ☐ Ex - Smoker ☐ Smoker, please state quantity per day _____

b) Nutrition ☐ Vegetarian ☐ Non-vegetarian Dietary Habits _____

c) Alchohol Consumption ☐ Daily ☐ Occasional ☐ Never * please proceed to question (d)

How often do you have an alchoholic drink ? ☐ *Monthly or less* ☐ *2-4 times a month* ☐ *4 or more a month*

How many standard alchoholic drinks on a typical day ? ☐ *1-2 drinks* ☐ *3-4 drinks* ☐ *5-6 drinks* ☐ *More than 6 drinks*

How often do you have 6 or more alchoholic drinks on one occasion ? ☐ *Never* ☐ *Monthly* ☐ *Weekly* ☐ *Daily or almost daily*

Are you concerned about your alchohol consumption ? ☐ *Yes* ☐ *No*

d) Physical Activity - Type & Duration per week _____

8 Immunisation

a) Have you had a Tetanus injection ? ☐ Yes, please state year _____ ☐ No ☐ Not sure

b) Have you had the Fluvax ? ☐ Yes ☐ No ☐ Not sure