Hall Road Medical Centre Patient Registration

Title	***Miss Mrs Ms Mr Dr Other***
First Name	
Surname	
Name known by	
Address ***Suburb/Postcode***	_____ _____
Date of Birth	
Medicare Number	***Ref -***
Mobile/Home Phone	
Email Address	
Centrelink Concession/Pension ***Card Number and Expiry Date***	***❑ HCC ❑ Pension ❑ DVA*** _____***exp***_____
Are you Aboriginal or Torres Strait Islander?	***If yes, you may be entitled to increased Medicare Benefits*** ***❑ No ❑ Aboriginal ❑ Torres Strait Islander***
Your cultural background may increase your risk of certain illnesses	***Country of Birth*** _____ ***Language Spoken***_____ ***Do you require an interpreter? ❑ Yes ❑ No***
Who is your NEXT OF KIN?	***Name*** _____ ***Relationship*** _____ ***Phone*** _____
Is your emergency contact the same as your Next of Kin? ***If <u>NO</u> who is the person you would like us to contact IN CASE OF EMERGENCY***	***❑ Yes ❑ No*** ***Name*** _____ ***Relationship*** _____ ***Phone*** _____
Do you consent to receiving SMS appointment reminders and/or health reminders/recalls?	***❑ Yes ❑ No***
Do you consent to us sharing medical information electronically or via phone with other Health Professionals?	***❑ Yes ❑ No***
Signature	***Date -***
Please note - If you cannot make your appointment, call 9783 0266 to let us know. Otherwise, there will be a minimum fee of $20 imposed for non-attendance.	

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Name: _____**DOB:**_____

Do you offer consent to participate in our health care reminders? YES NO
(E.g. Immunisations, skin checks, pap smears or annual health checks)

Your Medical History:

Are you allergic to anything? YES NO

If Yes, what? _____

Any previous operations? YES NO

If yes, give details: _____

_____

Do you have a chronic condition? (E.g. Asthma, High Blood Pressure, Diabetes or Other.)

_____

Current Prescribed Medications? (If you need more space, please write on the back.)

_____

_____

Do you have an immediate family history of any of the following?
(Please circle) – Do not include grandparents.

Diabetes Asthma Heart Disease Cancer Mental Illness Other

Social History:

Tobacco - Do you smoke – YES / NO How many per day? _____

Ex-smoker – YES / NO Year you quit smoking? _____

Alcohol - Do you drink alcohol – YES / NO

1. How often do you drink alcohol?
   ❑ Never ❑ Monthly or less ❑ 2-4 times a month ❑ 4 or more times a week
2. How many standard alcohol drinks do you have on a typical day?
   ❑ None ❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more
3. How often do you have six or more drinks on one occasion?
   ❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or almost daily

Please take this completed form with you and give to your doctor.