

Patient Registration Form

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|--|----------|---|-----------|
| Title: (Please Circle) Mr / Mrs / Ms / Miss / Mast | | Gender: (Please Circle) Male / Female / Other | |
| Surname: | | First Name: | |
| Preferred Name: | | Date of Birth: / / | |
| Address: | | | |
| | | | Postcode: |
| Postal Address: | | | Postcode: |
| Home Ph: | Work Ph: | Mobile: | |
| Email: | | | |

| | | |
|-----------------------------|---------|---------|
| Medicare No: | Ref No: | Expiry: |
| Pension/Healthcare Card: | | Expiry: |
| Dept of Veteran Affairs No: | | Expiry: |

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| Next of Kin / Emergency Contact person: | |
| Relationship to you: | |
| Address: | |
| Home Ph: | Mobile: |

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? No Yes – Please elaborate:

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| To assist with health initiatives – are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> No <input type="checkbox"/> Yes –Aboriginal <input type="checkbox"/> Yes –Torres Strait Islander | Do you Consent to Receive SMS to confirm appointments / Health reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No |
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How did you hear about us? Friend/Family Internet Walked by Other:

Patient Consent Clause

We need your permission to handle your personal data. To maintain your health, we use several reminder systems, where reminders or recalls may be issued via mail, email, phone, or SMS. The Privacy Act is followed by this practice. Please read our privacy statement before signing below. Feel free to ask us for more information if you have any questions about this.

I have read the HRMC Privacy Policy, and I give HRMC permission to share my personal health information with other healthcare professionals who are engaged in my medical care and treatment. I agree to get follow-up reminders and recalls as part of HRMC's preventative health and follow-up services.

Signature: _____ Date: _____

Patient History

Name: _____ Date of Birth: ____/____/____

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| Do You have a chronic illness? question | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Continue to next |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other – Please explain: | | |

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| Do you drink alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Continue to next question |
| How often do you drink alcohol? | <input type="checkbox"/> Monthly or less | <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 4 or more times a week |
| How many standard alcohol drinks do you have on a typical day? | <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 or more | |
| How often do you have six or more drinks on one occasion? | <input type="checkbox"/> Less than Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily | |

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| Do you Smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Continue to next question |
| How many per day? | | |

| | | |
|---------------------------------------|------------------------------|---|
| Are you allergic to anything? | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Continue to next question |
| Please list what you are allergic to: | | |

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|--------------------|------------------------------|---|
| Operations: | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Continue to next question |
| Details: | | |

| | | |
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| Are you taking any Medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No – Continue to next question |
| Please list your Medications: | | |
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| Are you aware of any medical conditions in your immediate family? (Siblings, Parents & Children)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Please explain: | | |