AQUA MARINE
MEDICAL CENTRE

Patient Registration Form

Title *Mr / Mrs / Miss / Ms / Master*

Surname _____ First Name _____Middle Name_____

Date of Birth _____ Preferred Name _____

Are you of Aboriginal descent or Torres Strait Islander descent?  

☐ *No* ☐ *Yes - Aboriginal* ☐ *Yes – Torres Strait Islander* ☐ *Both*

What is your preferred language? _____What is your Nationality? _____

Address: _____

Suburb _____ Postcode _____

Telephone Home _____ Work _____

Mobile _____ Email _____

Medicare Card Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ IRN _____ Expiry_____

Pension Card Number _____Expiry _____ Aged Disability Other

Healthcare Card Number _____ Expiry _____

Dept of Veteran Affairs Card Number _____ Expiry _____

Occupation _____Relationship De-Facto Married Single
Widowed Divorced Separated

Next of Kin Name: _____Phone _____Relationship _____

Emergency Contact _____ Phone _____ Relationship _____

I Give Permission for my details to be registered with my Health Record and Summaries to be uploaded to the National My Health system.
Please tick if permission *not given.* ☐

I hereby give express permission to Aqua Marine Medical staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf.
I acknowledge that I am wholly responsible to arrange any further appointments to discuss test results conducted by my Doctor at all times.
I give permission to be notified by letter, phone, email or text message for all Routine Recalls and Reminders.
I give consent to access the Pap Smear Register. - *If required.*
HIC Online, For Eligible Bulk Bill Patients -I hereby authorize Aqua Marine Medical Centre to process my claim through Medicare Australia.

Signed _____ **Dated** _____

Please tick if ☐ Parent ☐ Guardian

How did you hear about us? (Please tick)

☐ Google Search ☐ Health Engine ☐ Website ☐ Facebook ☐ Family / Friend ☐ Walk Past

☐ Radio ☐ Newspaper Other : _____

New Patient Medical History Form

All information is kept private and confidential and will help our doctors to give you a better long term treatment plan for your health requirements.

Surname: _____ First_____ D.O.B_____ Date_____

Who is or was you GP? _____ Suburb _____Phone_____

Current Height_____ Weight_____

Are you currently taking any medication?

_____

_____

Are you currently undergoing any medical treatment or had any operations recently?

_____

Do you smoke please tick ☐ Never ☐ 2-3 A Day ☐ 10 A Day ☐ 20 A day ☐ I Quit Date_____

Alcohol Usage ☐ Never ☐ 1-4 Std Drinks a week ☐ 4-8 Std Drinks a week ☐ 1-2 Std Drinks a Month

Are you allergic to any medication or materials? i.e Penicillin. Latex?

_____

Ladies, Last Pap Smear_____ are you pregnant? _____if yes when are you due _____

What brings you to our practice today _____

Have you ever had any of the following? Please tick those that apply on the left hand side.

	High/Low Blood Pressure		Epilepsy		Heart Surgery/Attack
	Rheumatic Fever		Diabetes Type 1 ☐ Type 2 ☐		Heart Complaint
	Allergies or Hives		Hepatitis A, B, C		Asthma or Breathing Problems
	Arthritis or Back Pain		Anaemia		Steroid Therapy
	Stroke		Contact with HIV/AIDS		Kidney Disease
	Emphysema		Stomach Ulcers		Tuberculosis
	Bleeding Disorder		Thyroid Disease		Sinus Therapy
	Depression or Mental illness		Diarrhoea or bowel trouble		Indigestion or reflux
	Artificial Joint		Liver Disease		Cancer

Is there anything else you would like to tell us about your general health?

_____

_____

_____

Admin Internal use. ☐ Keyed into BP ☐ Medicare Checked Initials_____ Scanned into BP Initials _____