

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.

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