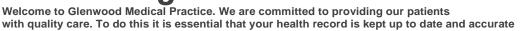
## Patient Registration Form





| YOUR PERSONAL DETAILS  |   |  |   |                                |
|--|---|--|---|--------------------------------|
| irst name:   |   | Title: Mr. Mrs. Ms. Miss Other:  |   |                                |
| Middle name:   |   | Preferred name:  |   |                                |
| Last name:   |   |  |   |                                |
|  |   | Date of birth: / /   |   |                                |
| Gender ID: Male Female Non-Binary Trans Gender Diverse   |   | Birth Sex: Female Male Other   |   |                                |
| YOUR RESIDENTIAL ADDRESS   |   |  |   |                                |
| Street name & no.:   |   | City/Suburb:   |   | P/code:                        |
| YOUR POSTAL ADDRESS (IF DIFFERENT FROM RESIDEN   |   |  |   |                                |
| Street name & no.:   |   | City/Suburb:   |   | P/code:                        |
| YOUR CONTACT DETAILS   | Morte   |  | Hamai   |                                |
| Mobile:  | Work:   |  | Home:   |                                |
| Email:   |   |  |   |                                |
| Would you like to receive clinical reminders via text messaging?   | Yes N   | No Preferre  | d contact: Mail   | ☐ Email                        |
| YOUR OCCUPATION  |   |  |   |                                |
| Occupation:  |   |  | Une   | mployed Retired                |
| YOUR RELATION TO HEALTH INITIATIVES - DO YOU IDEN  | ITIFY YOURSELF AS ABO   | RIGINAL OR TORRES  | S STRAIT ISLANDER?  |                                |
| ☐ No ☐ Aboriginal ☐ Torres   | s Strait Islander   | Aboriginal and To  | rres Strait Islander  |                                |
| If no, what is your cultural background?   |   |  |   |                                |
| YOUR MEDICARE INFORMATION  |   |  |   |                                |
|  | Line No.:   | Expiry:  | //  |                                |
| Medicare No.:  |   | 1 /  |   |                                |
| YOUR PENSION INFORMATION (IF APPLICA   | BLE)  |  |   |                                |
| Pension/HCC No.:   | Ref No.:  | Expiry:  | //  |                                |
| Card type:   |   |  |   |                                |
| DVA No.:   |   |  |   |                                |
|  |   |  |   |                                |
| YOUR NEXT OF KIN:  |   |  |   |                                |
| Name:  | Relation:   |  | Phone:  |                                |
| YOUR EMERGENCY CONTACT please tick b   | ox if same as Next of F   | Kin  |   |                                |
| Name:  | Relation:   |  | Phone:  |                                |
| OUR PRIVACY & CONFIDENTIALITY Glenwood Medical Practice collects information from you t is important that you do not withhold information that wo We are committed to patient privacy and confidentiality are law requires us to do so. Please do not hesitate to discuss any concerns or questic by becoming a patient of Glenwood Medical Practice and | ould influence the medicand will only release informons about any issues to t | al treatment or advice<br>mation about you to<br>he privacy of your po | e given. other health professional ersonal information with | als involved in your care or w |

treatment and health care within this center.

I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly

involved in my personal health care or medical treatment.

As part of preventative health services offered by this practice, we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls as necessary.

| YOUR SIGNATURE | DATE |  |
|----------------|------|--|
|                |      |  |

| YOUR HEALTH HISTORY  Do you consent to Glenwood Medical Practice GPs accessing your 'My Health Record' for the purpo   | ose of ongoing medical care? |  |  |  |  |
|--|------------------------------|--|--|--|--|
| ☐ Yes ☐ No ☐ I have 'Opted Out' for My Health Record   |                              |  |  |  |  |
| Do you have any allergies or are sensitive to drugs or dressings?   — Yes – Please list below                          | □ No                         |  |  |  |  |
|  |                              |  |  |  |  |
| Do you or have you ever had any of the following conditions?   | pelow 🗆 No                   |  |  |  |  |
| □ Diabetes □ Asthma □ Heart Problem  | ☐ Anxiety                    |  |  |  |  |
| □ Kidney Disease □ Epilepsy □ High Blood Pressure  | □ Depression                 |  |  |  |  |
| □ Colon Cancer □ Breast Cancer □ Stroke  | ☐ Other                      |  |  |  |  |
| YOUR BLOOD GROUP  Do you know your blood group? □ Yes, my blood group is □ No  |                              |  |  |  |  |
| FOR YOUR CHILD (TO BE COMPLETED IF THIS FORM IS FOR YOUR CHILD) Is your child up to date with his / her immunisations? |                              |  |  |  |  |
| VOLID DEL ATION TO TORACCO   |                              |  |  |  |  |
| YOUR RELATION TO TOBACCO  ☐ I have never smoked ☐ I smoke ☐ I ceased smoking (please advise date)//                    |                              |  |  |  |  |
| YOUR RELATION TO ALCOHOL  Do you drink alcohol? □ Yes □ No □ Socially  |                              |  |  |  |  |
| FOR FEMALE PATIENTS  Please provide the date of your last Cervical Screening Test//                                    |                              |  |  |  |  |
| REFERRAL SOURCE – How did you hear about this medical practice?  |                              |  |  |  |  |
| □ Word of mouth □ Drive / walk past □ Leaflet / Flyer  | □ Website □ Google           |  |  |  |  |
|  |                              |  |  |  |  |
| OFFICE USE ONLY  |                              |  |  |  |  |
| Admin 1. PATIENT ID HAS BEEN SIGHTED (ie. Medicare card or D/L) □  | INTIALS: DATE://             |  |  |  |  |
| Admin 2. ALL ADMINISTRATIVE INFORMATION HAS BEEN ENTERED   INTIALS: DATE://  |                              |  |  |  |  |
| Admin 3. ALL CLINICAL INFORAMTION HAS BEEN ENTERED   | INTIALS: DATE://             |  |  |  |  |
| Nurse 4. FORM HAS BEEN SCANNED TO PATIENT FILE □   | INTIALS: DATE: / /           |  |  |  |  |