ABERFOYLE PARK FAMILY PRACTICE

PATIENT REGISTRATION FORM

PLEASE HAND THIS PAGE BACK TO STAFF ONCE COMPLETED, DO NOT LEAVE ON FRONT DESK.

Title (please circle)	**Mr Mrs Miss Master Ms Dr Other……**	
First Name (as it appears on Medicare Card)		
Surname (as it appears on Medicare Card)		
Date of Birth		
Medicare Card No.	__ __ __ __ __ __ __ __ __ __ **Ref No.** __ **Expiry Date:** __ __ / __ __	
DVA Number (Dept of Veterans' Affairs)	__ __ __ __ __ __ __ __ **Expiry Date:** __ __ / __ __ / _ _	
Pension No. (Centrelink)	__ __ __ __ __ __ __ __ __ __ **Expiry Date:** __ __ / __ __ / _ _	
Health Care Card No. (Centrelink)	__ __ __ __ __ __ __ __ __ __ **Expiry Date:** __ __ / __ __ / _ _	
Home Address (Residential Address)		
Postal Address (if different from above)		
Home Phone No:		
Mobile No:		**Do you consent to SMS reminders of your upcoming appointments?** **Yes / No** (Please circle)
Email:		
Work Phone No:		
Patient's Occupation		**Do you consent to SMS notifications for your Health Recalls and Reminders?** **Yes / No** (Please circle)
Country of Birth		
Next of Kin	**Name:**_____ **PH:** _____ **Relationship to you (i.e. mother)** _____	
Emergency Contact (Ideally not the same as your next of kin)	**Name:** _____ **PH:** _____ **Relationship to you**_____	

Knowing your cultural background can help us provide health care that meets your individual needs
Are you of Aboriginal or Torres Strait Islander Origin?

□ No □ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander

□ Other cultural background (e.g. Mediterranean, Asian, African) _____

How did you hear about our clinic?	**Website Facebook Flyer/Brochure Yellow Pages Online** **Drive By Word of Mouth Other……**

Signature: _____ **Date:** _____

CHILDHOOD REGISTRATION FORM

To assist with maintaining an accurate record of your child's health, it would be appreciated if you took the time to complete the following information to the best of your knowledge.

****** PLEASE TAKE THIS COMPLETED FORM INTO THE DOCTOR WITH YOU ******

CHILD'S NAME: _____ DOB: _____

WAS YOUR CHILD BORN PREMATURELY: □ Yes □ No

DETAILS IF YES: _____

_____

WAS YOUR CHILD IN NICU: □ Yes □ No

DETAILS IF YES: _____

ARE YOU STILL BREAST FEEDING: □ Yes □ No

DOES YOUR CHILD HAVE ANY ALLERGIES YOU ARE AWARE OF: □ Yes □ No

_____

HAS YOUR CHILD HAD ANY OPERATIONS:

DETAILS**:** _____

_____

SIGNIFICANT FAMILY HISTORY: NIL KNOWN □

MOTHER

- □ DIABETES
- □ HIGH BLOOD PRESSURE
- □ CANCER site _____
- □ DEPRESSION
- □ HEART DISEASE
- □ ASTHMA
- □ OTHER _____

FATHER

- □ DIABETES
- □ HIGH BLOOD PRESSURE
- □ CANCER site_____
- □ DEPRESSION
- □ HEART DISEASE
- □ ASTHMA
- □ OTHER _____

ARE YOU CHILD'S IMMUNISATIONS UP TO DATE: □ Yes □ No

Your privacy is very important to us. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorized members of staff. The information collected in this form will be kept confidential at all times. All staff employed at this clinic are bound by a confidentiality agreement in accordance with accreditation standards.