NEW PATIENT REGISTRATION FORM

Please circle where required.

Title	**Mr**	**Mrs**	**Ms**	**Mstr**	**Miss**	**Other:**
First Name			**Last Name**		
Known As			**Date of Birth**		
Sex at Birth	**Male**	**Female**	**Not Stated**	**Intersex/Other:**	
Gender Identity	**Male**	**Female**	**Intersex**	**Indeterminate**	**Prefer not to say**	**Other:**
Medicare No			**Patient No:**		**Exp Date:**
Do you identify as Aboriginal or Torres Strait Islander?	**Aboriginal**	**Torres Strait Islander**	**Both**	**Neither**	**Prefer not to say**	
Home Address					
Postal Address **If diff. from above**					
Contact Number/s	**Mobile:**		**Work:**		**Home:**
NOK details	**Name:**				
	Phone:				
	Relationship:				
Country of Birth					
Ethnicity					
DVA Card	**White / Gold**		**DVA Number:**		
Centrelink Concession Cards: **Pensioner** **Commonwealth Seniors Health** **Health Care Card**	**CRN:**				**Exp Date:**
If filling out form for a CHILD, please provide	**Parent name:**				
	Parent date of birth:				

I am happy to receive SMS reminders from the Practice ☐ Yes ☐ No

Once you have completed filling in this form, please return it to one of our reception staff ASAP.

PATIENT INFORMATION

Please read through the following information carefully and sign to indicate you understand and agree to these policies.

Fees
Campbell Medical Practice is a private billing practice. All fees are payable at the time of consultation. Telehealth appointments are charged at the same rate as face-to-face appointments.

Late Arrival and No Show
If you are more than 5 minutes late to a scheduled appointment, then you will be considered to have missed your appointment and will need to reschedule.
If you miss an appointment this will be noted in your file. If you fail to attend 3 scheduled appointments, a no-show fee of $40 will be payable to the practice.

Privacy Policy
Campbell Medical Practice may be required to collect personal information about you (or your child/dependent). Your personal health information may be disclosed to others involved in your healthcare, such as other doctors and health care providers. Further information on how Campbell Medical Practice collects and uses your health information can be found in our privacy policy, available at front reception.

CONSENT

By signing this form, I acknowledge the above policies of Campbell Medical Practice:

Patient's Name: _____ DoB: _____

Signed: _____ Date: _____

(Patient / Parent / Guardian)

HEALTH HISTORY FORM

Campbell Medical Practice is committed to providing their patients with the best care.

To do this it is essential that your medical records are up to date and accurate. Please assist your doctor by completing the following:

First Name:	**Surname:**	**DOB:**

Do you have or have ever had a history of?

☐ Operations ☐ High blood pressure ☐ Asthma ☐ Epilepsy ☐ Diabetes

☐ Any other major health event or illness (please use the space below):

_____

_____

Do you have any ALLERGIES or are you SENSITIVE to DRUGS or DRESSINGS?

☐ Yes (If yes, please list below) ☐ No

_____

_____

IMMUNISATIONS - Have you had the following immunisations?

Tetanus booster	date_____	☐ Do not Know	☐ Have not had one.
Hepatitis B or A	date_____	☐ Do not Know	☐ Have not had one.
Influenza	date_____	☐ Do not Know	☐ Have not had one.
Pneumococcal	date_____	☐ Do not Know	☐ Have not had one.
Polio	date_____	☐ Do not Know	☐ Have not had one.

Children's Immunisations - If completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No ☐ Do not know

Current MEDICATIONS (including over the counter medications, vitamins, and minerals)

_____

_____

_____

SMOKING STATUS/ALCOHOL CONSUMPTION

☐ Tobacco: _____day / week Ceased Smoking - date _____

☐ Alcohol: _____day / week / month (circle the one applicable)

☐ Drug use: _____(type and how often used?)

FAMILY MEDICAL HISTORY - Have any members of your family had?

☐ Diabetes ☐ Mental illness ☐ Asthma ☐ Heart Disease

☐ Cancer (e.g., Bowel, Prostate, Breast, Melanoma?) ☐ Other? _____

For Females:	**When did you last have?**		
Pap Smear	Date _____	☐ not sure	☐ never
Mammogram	Date _____	☐ not sure	☐ never

For Males:	**When did you last have?**		
An overall check-up	Date _____	☐ not sure	☐ never

Please take this form into the doctor with you, thank you.

- (This section for Nurse or GP to complete) -

Height: _____cms **Weight:** _____kgs **Blood Pressure:** _____