New Patient Registration Form

Skye Medical Armadale

The Pinnacle of Primary Care

We need this information to provide the best quality care. Your personal health information is kept private and secure as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP

PERSONAL DETAILS

Dr / Mr / Mrs / Ms / Miss / Master

First Name: _____ Surname: _____

Middle Name(s) : _____ Known as:_____

Date of Birth: ____|____|____

Medicare Number:_____ Reference:_____ Expiry: ____|____

Please tick if appliciable:

☐ Pensioner Concession Card Number: _____ Expiry:_____

☐ Health Care Card Number: _____ Expiry:_____

☐ Dep. of Veteran Affairs Number:_____Colour: _____

Gender at birth: ☐ Female ☐ Male Identifies as: ☐ Female ☐ Male ☐ Non Binary

Preferred pronouns: ☐ She/Her ☐ He/Him ☐ They/Them

Home Address: _____

Suburb:_____ Postcode: _____

Mobile Phone No:_____ Home Phone No: _____

Email: _____

Occupation: _____

Next of Kin—Name:_____ Phone: _____

Address: _____

Relationship to you: _____

Emergency Contact—Name: _____ Phone:_____

Relationship to you: _____

How did you hear about Skye medical Armadale? _____

CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs

Are you Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Country of Birth: _____

Cultural background (eg Mediterranean, Asian, African) _____

Is English your first language? ☐ Yes ☐ No

If not, do you require an interpreter? ☐ Yes ☐ No Please specify language_____

MEDICAL HISTORY

Smoking Status

☐ I have never smoked

☐ I currently smoke How many a day? _____

☐ I used to smoke When did you start? _____ When did you quit? _____

CONTINUED ON THE NEXT PAGE

Do you drink alcohol?

☐ No

☐ Yes How many a day?_____ How many a week?_____

Allergies: _____

_____

Current Medications: _____

Chronic illness/Condition (eg; Diabetes, asthma): _____

_____

Do you have children ☐ No ☐ Yes How many? _____

Date of last cervical screening? _____ Result (if known): _____

Family History: _____

Do you have any other questions, comments or concerns you would like your doctor to know?

_____

Have you attended another GP Surgery, specialist or visited hospital?
If so, please speak to reception so we can organise to get your records transferred.

CONSENT

My medical records and information may be used by the practice and practitioners to provide me with honest medical care.

My medical information may be released to other health professionals involved in my treatment.

ALL work place injuries and workers' compensation visits at this practice will attract PRIVATE fees to be paid at the time of my appointment.

I may be subject to a cancellation or non-attendance fee if I cancel my appointment within 2 hours of the appointment time or fail to attend.

Our practice uses a reminder system to help maintain your health.
The practice sends reminders for procedures such as vaccinations, cervical screening and other health reviews as well as appointment reminders.
SMS reminders are sent via a third party provider (HotDoc)
I consent to being contacted via SMS via HotDoc ☐ Yes ☐ No

Occasionally, the practice may contact you via e-mail
I consent to being contacted via e-mail ☐ Yes ☐ No
If you are not happy to be contact via SMS or e-mail, you will only be contacted via telephone or letter

Please ask our reception team if you would like a copy of our privacy policy

Signature of patient or guardian_____ Date_____