PBB HEALTH CENTRE

New patient registration form

Please print letters

Use black or blue pen

Place [X] in all applicable boxes

We need this information to provide the best quality health care. Your personal information is kept private and secure, as required by federal and state privacy laws. If you have any concerns please leave blank and discuss with your GP, midwife or nurse. Please notify us promptly of any changes in your contact details. Having accurate contact details helps us to identify you and your medical records and allows us to contact you about tests and results.

SECTION A: Personal details

Title | Surname | Given names

Date of birth / / | Gender Male ☐ Female ☐ | Marital status Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐

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

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Other cultural background(Mediterranean, Asian, African) | Country of birth

Is English your first language? Yes ☐ No ☐ | If not do you require an interpreter? Yes ☐ No ☐ | Please specify language

Home address | Suburb | Postcode

Postal address | Suburb | Postcode

Telephone Number | Work number | Mobile number

Email

Medicare Card Number | Card reference number | Expiry date / /

Pension, Health Care Card or Veterans Affairs number (if applicable) | Type of Veterans Affairs Card | Expiry date / /

Health Insurance Fund | Health Insurance No. | Expiry date / /

PLEASE TURN OVER PAGE TO COMPLETE BACK OF THIS FORM

Occupation

Religion

Next of Kin?

Name

Relationship to you

Telephone Number

Work number

Mobile number

Who can we contact in an emergency?

Name

Relationship to you

Telephone Number

Work number

Mobile number

SECTION B: **Allergies**

List allergies and intolerances to medication

Describe your reaction i.e rash, nausea

	Mild/Moderate/Severe
	Mild/Moderate/Severe
	Mild/Moderate/Severe

Medication - List regular medications and dosages and complementary medications and dosages

SECTION C: **Consent**

Our practice uses a reminder system to help you maintain your health. This practice sends out reminders by post, email, telephone and SMS for procedures such as pap smears, health reviews and vaccinations.

I consent to an SMS being sent to my mobile to confirm my appointments.
Yes ☐ No ☐
I consent to being contacted for reminders to help maintain my health.
Yes ☐ No ☐

Signature of patient or guardian

Date / /

SECTION E: **Transfer of health information**

You may have consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or summary of your health records transferred to this practice. Please ask the receptionist for information on how this can take place.

Please advise us if your contact information or Medicare details change.

Office use only; Entered by _____
Medicare online verification done (please circle) yes/no
HIP-I number entered (please circle) yes/no