New Patient Registration Form

SOUTHERNSTAR MEDICAL

☐Mr ☐Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other, Please List: _____

Surname: _____ Given Name: _____

Middle Name: _____ Preferred Name: _____

Date of Birth: ____/_____/_____ Age: _____ Birth Sex / Gender: ☐Male ☐Female ☐Other

Gender Identity: ☐Male ☐Female ☐Transgender ☐non-binary ☐Gender Diverse ☐ Different identity

Occupation: _____ **Marital Status:** ☐ Single ☐ Married ☐ De Facto ☐ Widowed

What ethnicity group do you identify with: _____ What Country were you born in? _____

Are you of or from Aboriginal or Torres Strait Islander Origin? ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Street Address: _____

City/Suburb: _____ Postcode: _____

Home Phone: _____ Mobile: _____ Work Phone: _____

E-mail: _____

Do you Given Consent to be contacted via details provided above (Phone Call, SMS, Post/ Letter, Email) ☐ Yes ☐ No

Medicare Number: _____ Ref No: (Next to Name) _____ Expiry Date: _____

☐ Health Insurance Fund: _____ Membership No: _____

☐ Health Care Card ☐ Pension Card No: _____ Expiry Date: _____

☐ Department of Veteran Affairs Card Number: _____ Expiry Date: _____

DVA Card colour: ☐ GOLD ☐ WHITE ☐ Orange

I authorise the following people to be contacted in the case of an emergency:

NEXT OF KIN: Name: _____ Relationship: _____ Contact No: _____

EMERGENCY: Name: _____ Relationship: _____ Contact No: _____

Please see Reception if you are seeing the doctor regarding a Workers Compensation or Motor Vehicle Accident Claim for billing information
Please be aware you may be charged a Fee of $60, if you miss an appointment or fail to cancel an appointment with 2 hours' notice.

My Health Record is a secure online summary of an individual's health information.
If you have Medicare you are automatically Registered, unless you have personally opted out via your MyGov account.
Would you like a personalized Health Summary updated on to your 'My Health Record'? ☐Yes ☐No

Privacy Statement

Your Personal Health Information and your Medical Records may be collected, used and disclosed, including but not limited to the following reasons:

- For Communicating relevant information with other treating doctors, specialists or allied health professionals
- For follow up reminders/recall notices
- For Contacting you regarding patient feedback.
- For disease notification as required by law (e.g., infectious diseases)
- For use by all doctors in this practice, when consulting with you
- For research purposes (de-identified, meaning you are not able to be identified from the information given)
- For obtaining previous pathology and radiology results.
- For uploading/downloading & accessing information on your personal 'My health Record'.

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your doctor.

Signature: _____ Date: _____

Reception Use Only:
☐ Scanned
☐ Entered
Reception Signature

TURN PAGE OVER >>>>>>>>
PLEASE COMPLETE OPPOSITE SIDE

New Patient Registration Form

SOUTHERNSTAR MEDICAL

Do you have any allergies? ☐ No, Nil Known Currently ☐ Yes, Please List:

Item (e.g. Bees, Penicillin)	Reaction type (e.g. Hives, Nausea)	Severity
		☐ Mild ☐Moderate ☐Severe
		☐ Mild ☐Moderate ☐Severe
		☐ Mild ☐Moderate ☐Severe

Significant Family History: ☐ Unknown (e.g., Adopted)

Mother: ☐ Nil ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Mother Alive? ☐ Yes ☐ No Other Significant Family History: _____

Father: ☐ Nil ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Prostate Cancer

Father Alive? ☐ Yes ☐ No Other Significant Family History: _____

Do you use any of the following?

Alcohol: ☐ No. ☐ Yes ☐ Ex-Drinker. Days per week ____ Standard drinks per day ____ Age Started: ____ Age Stopped: ____

Past Alcohol Intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Smoker: ☐ No. ☐ Yes ☐ Ex-Smoker. How many per day _____ Age Started: _____ Age Stopped: _____

Medical History

Do you have any medical problems? ☐ No, Nil Known Currently ☐ Yes, Please List:

Date diagnosed	Problem:

Do you have a history of mental illness? ☐ No, Nil Known Currently ☐ Yes, Please List:

Date diagnosed	Type

Have you had any surgery? Please List and provide details ☐ No, Nil Known Currently ☐ Yes, Please List:

Date Performed	Procedure:

What medications do you currently take? Please list with doses: ☐ No, Nil Known Currently ☐ Yes, Please List:

Name	Dose	Reason:

Females:	(optional) When was your last pap smear? DD/MM/YYYY Was it normal? Yes / No (optional) Please list how many: Pregnancies: ____ Births: _____ Miscarriages: _____ Terminations: _____ (optional) When was your last mammogram? _____
Males:	(optional) (>40 years): When was your last prostate check? _____

Do you regularly see other specialists? Please list Who and where:

Name	Where

END OF FORM

Reception Use Only:
☐ Scanned
☐ Entered
Reception Signature