ERAMOSA
FAMILY MEDICAL CENTRE

Online Booking Available
www.eramosamedical.com.au

PATIENT REGISTRATION FORM

CONTACT DETAILS

Title:________ Given names: ___________________________ Surname: ___________________________________

Preferred Name:________________________ DOB: ____/____/____ Gender: ☐ Male ☐ Female ☐ Other

Address: ____ Suburb: _________________________ P/C: _______

Contact Numbers: Home: ___________________ Work: ___________________ Mobile: _____________________

Email: ________________________________@___________________ Occupation: __________________________

Medicare No:_______________________________________ Ref No:__________ Expiry Date: ____________

Vet Affairs No:______________________________________ Ref No:__________ Expiry Date: ____________

Pension/Health Care Card No:____ Expiry Date: ____________

If patient is a minor, who is responsible for the account?

First Name: __________________________ Surname: _________________________________ DOB: ____/____/____

Medicare No: ____ Ref No:__________ Expiry Date: ______________

NEXT OF KIN

First Name: __________________Surname:_______________________ Relationship to patient: ________________

Contact Numbers: Home: ____________________ Work: __________________ Mobile: _____________________

EMERGENCY CONTACT

First Name: __________________Surname:_______________________ Relationship to patient: ________________

Contact Numbers: Home: ____________________ Work: __________________ Mobile: _____________________

How did you hear about us? ☐ Google ☐ Facebook ☐ Website ☐ Signage ☐ word of mouth ☐ Yellow Pages

To assist with health initiatives are you an Aboriginal or Torres Strait Islander?
☐ Neither ☐ Aboriginal ☐ Torres Strait ☐ Both

To assist us in determining disease risk factors, what is your ethnic background? ______________________________

FEES AND CHARGES

I agree to pay all fee and charges that may not be covered under Medical Benefit Scheme (MBS), Insurance Plans or under mandatory WorkCover Insurance maintained by my employer. I understand that in the event of late payment, the general practice reserves the right to charge the patient / guardian a reasonable account management fee and may take legal action if the necessary payments are not made in time. I also understand that the cancellation of any future appointments requires a minimum two-hour notice and that I may be charged a Non-attendance Fee if I or the person I care for failed to do so.

PRIVACY PROTECTION

I understand that my rights to privacy are protected under the “Privacy Act 1988” and the “Privacy Amendment (Private Sector) Act 2000”. With this knowledge, I give permission to be contacted through electronic means provided by myself or by the person in charge of my care. I allow the health information of the person in this registration form to be collected, used, disclosed or shared to enable the primary purpose of ongoing care and the secondary purpose of quality improvement, population health planning, and research. This may include, accounting procedures for the account management, diagnosis and treatments, Quality Assurance, general practice accreditation, Legal disclosures required by a court of law, population health planning, research, medical training/teaching, for seeking treatment by other medical practitioners in the practice and/or disease notification as required by law. The information may be collected through medical test results, consultation notes, Medicare and health insurance details, specialists’ correspondence and/or other relevant sources.

DIGITAL HEALTH

Eramosa Family Medical Centre participates, collects and complies with all the Digital Health Authority initiatives for electronically connecting the points of care so that your health information can be shared securely. We do so to help in facilitating to a connected system where every Australian is at the centre of their healthcare

Signature: ____ **Date:** ______________________

Name: ____ **DOB**: ____/____/____

MEDICAL HISTORY

Do you have any allergies or sensitivities including in medicines or dressings?

☐ No ☐ Yes (please list) ____

____

Are you currently using any prescribed or over the counter medications or vitamins and minerals?

☐ No ☐ Yes (please list)

____

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Do you have or have you ever had a history of:

Heart problems	☐ No ☐ Yes	Serious Trauma, or operations	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
Asthma, respiratory problems	☐ No ☐ Yes	Abnormal pap smear	☐ No ☐ Yes
Ear or hearing problems	☐ No ☐ Yes	Mental health	☐ No ☐ Yes
Eye or vision problems	☐ No ☐ Yes	Arthritis	☐ No ☐ Yes
Migraine	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes

Other: (please list):

PREVENTATIVE HEALTH

When was your last check for the following (approximately):

			MALE			
Cholesterol	Date:	☐ Not Sure ☐ Never	Prostate	Date:	☐ Not Sure ☐ Never	
			FEMALE			
Blood Pressure	Date:	☐ Not Sure ☐ Never	Pap Smear	Date:	☐ Not Sure ☐ Never	
Diabetes Check	Date:	☐ Not Sure ☐ Never	Breast Check	Date:	☐ Not Sure ☐ Never	
Faecal Occult Screening	Date:	☐ Not Sure ☐ Never	Mammogram	Date:	☐ Not Sure ☐ Never	

Patients 45-49: Have you had a recent health assessment, including blood tests ☐ No ☐ Yes

IMMUNISATIONS

If patient is a child, is your child immunisation schedule up to date? ☐ Yes ☐ No ☐ Not Sure

Date of last Tetanus vaccine: ___/___/___

FAMILY HISTORY

Diabetes	☐ No ☐ Yes	Mental Illness	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes	Auto Immune	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	Other:	

SOCIAL HISTORY

Do you exercise?	☐ No ☐ Yes	How many times per week?	Duration of exercise?
Do you smoke?	☐ No ☐ Yes	How often?	Smoking for how many years?
		If ceased, approx. date:	
Do you drink alcohol?	☐ No ☐ Yes	How many days per week?	Number per occasion?
Do you use recreational drugs?	☐ No ☐ Yes	How often?	What type?

OTHER RELEVANT INFORMATION

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