nvmc NARANGBA VALLEY MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Mr Mrs Ms Miss Mast Dr

Surname: _____ First Name: _____

Date of Birth ____/____/____ Email address:_____

PLEASE TICK or CIRCLE: Birth Sex: Female Male Other Unknown

Gender Identity: Female Male Non-Binary Gender Diverse Transgender Different identity

Pronouns: She/Her/Hers He/Him/His They/Them/ Theirs

Home address: _____Postcode: _____

Day Time Phone:_____ Mobile:_____ Work:_____

Emergency contact:_____ relationship: _____ Ph Number:_____

Next of Kin:_____ relationship:_____ Ph Number:_____

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Cultural background: PLEASE TICK or CIRCLE:

Aboriginal Torres Strait Islander Australian Other – please specify _____

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ____ ____ Ref No: _____ Expiry date: ____/____

DVA Gold Card No: _____ or DVA White Card No: _____

Pension Number: _____ Expiry date: _____

Health Care Card Number: _____ Expiry date: _____

Preferred Communication: Mobile Phone Home phone Mail

Consent to SMS Reminder: Yes No

Allergies - Yes No If yes please list all allergy reactions _____

_____

Please list any medical history and past surgery/operations/previous illness/injuries:

_____

_____

Please list current medication _____

_____

Height _____cm Weight _____ kg

PLEASE TURN OVER FOR MORE DETAILS…..

IMMUNISATIONS (please tick relevant boxes)

Pneumococcal (pneumonia) Influenza Tetanus Childhood vaccines up to date

Other (please specify) _____

GENDER RELATED HEALTH HISTORY

Women's Health

Last pap smear _____

Last mammogram _____

Men's Health

Last prostate check (if aged over 40) _____

LIFESTYLE HEALTH HISTORY

Smoking History

Never

Former smoker – quit date _____

Current smoker - _____ cigarette per day

Number of years smoking _____

Alcohol

Non-drinker

Rarely/light Days per week _____

Moderate Glasses per day _____

Heavy Glasses per day _____

FAMILY HISTORY - Have you ever had / or family history of:

Diabetes	Mother	Father	Brother/Sister	Grandparent
Heart Disease	Mother	Father	Brother/Sister	Grandparent
Stroke	Mother	Father	Brother/Sister	Grandparent
Asthma	Mother	Father	Brother/Sister	Grandparent
Cancer	Mother	Father	Brother/Sister	Grandparent

If yes to cancer question, please specify what kind: _____

In accordance with the Privacy Act (1988), all information collection in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your healthcare. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.

Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. Pathology & Radiology).

I provide my consent to assign the bulk billing benefit to the treating doctor

I have no objection to send my health information via email or SMS

I Consent to the use of my personal health information by Narangba Valley Medical Centre and other health providers involved in my medical treatment and health care directly or indirectly. I Consent to contact my next of kin in case of an emergency.

I have read the Practice Information and agree with the terms and conditions. Please obtain a copy of our Practice Information from our Receptionists or visit our website. I agree to advise Narangba Valley Medical Centre of any changes to my contact details.

Signature: _____ Date: _____/_____/_____