nvmc NARANGBA VALLEY MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Title (please circle): Mr Mrs Ms Miss Mast Dr

Surname: _____ First Name: _____

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

_____

Birth Sex (please circle): Female Male Other Unknown

Gender Identity (please circle): Female Male Non-Binary Gender Diverse Transgender Different identity

Pronouns (please circle): She/Her/Hers He/Him/His They/Them/ Theirs

Home address: _____ Suburb: _____ Postcode: _____

Day Time Phone: _____ Mobile: _____ Work: _____

Emergency contact name: _____ Relationship: _____ Ph Number: _____

Next of Kin name: _____ Relationship: _____ Ph Number: _____

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Cultural background (please circle): Aboriginal Torres Strait Islander Australian Other – _____

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

DVA Gold Card Number: _____

DVA White Card Number (please provide list of approved conditions): _____

Pension Concession Care Number: _____ Expiry date: _____

Health Care Card Number: _____ Expiry date: _____

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Preferred Communication (please circle): Mobile Home Phone Mail **Consent to SMS Reminder (please circle):** Yes No

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Allergies: Yes No

If yes, please list all allergy reactions: _____

_____

Please list current medication (Include over the counter medication): _____

_____

Height: _____ cm Weight: _____ kg

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Immunisations (please circle all relevant immunisations): Pneumococcal (pneumonia) Influenza Tetanus

Childhood Vaccines (up to date) Other (please specify): _____

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NARANGBA VALLEY MEDICAL CENTRE

Gender Related Health History

Women's Health: Last Pap Smear / Cervical Screen: _____ Last Mammogram: _____

Men's Health: Last Prostate Check (if aged over 40): _____

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Lifestyle Health History

Smoking History (please circle/complete):

Never

Former Smoker – quit date: _____

Current Smoker: _____ cigarettes/day

Number of years smoking: _____

Alcohol History (please circle/complete):

Non-drinker

Rarely/Light - ____ Days/week

Moderate - ____ Glasses/day

Heavy - ____ Glasses/day

****

Family History

Have you ever had / or do you have a family history of (please circle):

- Diabetes Self Mother Father Brother/Sibling Grandparent
- Heart Disease Self Mother Father Brother/Sibling Grandparent
- Stroke Self Mother Father Brother/Sibling Grandparent
- Asthma Self Mother Father Brother/Sibling Grandparent
- Cancer Self Mother Father Brother/Sibling Grandparent

If yes to Cancer, 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 any available bulk billing benefit to the treating doctor.

☐ I provide my consent to send my health information via email or SMS.

☐ I provide my consent to the doctor to utilise AI technology during my consultation.

☐ I provide my consent to the use of my personal health information by Narangba Doctors and other health providers involved in my medical treatment and health care directly or indirectly.

☐ I provide my consent to contact my next of kin in case of an emergency.

☐ I agree to advise Narangba Doctors of any changes to my contact details.

☐ I have read the Practice Information and agree with the terms and conditions.
You can obtain a copy of our Practice Information from our Receptionists or by visiting our website.

Signature: _____ Date: _____/_____/_____