THE JUNCTION GENERAL PRACTICE

REGISTRATION FORM FOR NEW PATIENTS

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

Practice name Section A: Personal details

Title: _____

Surname: _____

Given names: _____

Date of birth: _____

Gender: _____

Marital status: (please circle) Single/ Married / Defacto / Separated / Divorced / Widowed

Medicare card no. __ __ __ __ __ __ __ __ __ __

Medicare reference no. _____

Expiry date: _____

Pension, Health Care Card, or Veterans Affairs number: __ __ __ __ __ __ __ __ __ __

Type of Veterans Affairs card: _____

Expiry date: _____

Occupation: _____

Home address: _____

Postcode: _ _ _ _

Postal address: _____

Postcode: _ _ _ _

Home phone number: _____

Work phone number: _____ Mobile number: _____

Email: _____

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Next of Kin

Name: _____

Relationship to you: _____

Home phone number: _____

Work phone number: _____ Mobile number: _____

Who can we contact in an emergency?

Name: _____

Relationship to you: _____

Home phone number: _____

Work phone number: _____ Mobile number: _____

Do you have an advance care directive for end of life care? Yes / No (For more information talk to your GP.)

Section B: Cultural background

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

Are you of Aboriginal or Torres Strait Islander origin?

Aboriginal: Yes / No Torres Strait Islander: Yes / No both Aboriginal and Torres Strait Islander: Yes / No

Other cultural background: (eg 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: _____

Section C: Allergies and medicines

List allergies and intolerances to medications:

List regular medications and doses, and complementary medicines and doses:

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Section D: Health Habits

Alcohol Consumption:

☐ I don't drink

Days per week: _____

Drinks per day: _____

Other: _____

Do you smoke?

☐ I don't smoke

Cigarettes per day: _____

Section E: Family Background

Do you have any significant family medical history? Please state below:

_____

_____

Section F: Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews.

I consent to being contacted with reminders to help me maintain my health Yes / No

Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move.

I consent to being contacted with reminders to help me maintain my health Yes / No

Signature of patient or guardian: _____

Date: _____

Section G: Transfer of health information

You may have consistently 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 a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

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