UPPER BEACONSFIELD GP PRACTICE

Better care together

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Patient Registration Form

Welcome to The Upper Beaconsfield GP Practice. We require this information to provide you with the best quality comprehensive care. Our clinic follows the guidelines of best practice for the management of health information in private practice. This means your personal health information is kept private and secure.

Your details

Title	First Name		Surname
Date of Birth / /		Age	(Circle) Gender: Male Female Other
Country of Birth		Occupation	

Home Address		
Suburb	State	Postcode
Mobile	Home	Work
E-mail:		
Are you an Aboriginal and/or Torres Strait Islander? Yes / No		
Ethnicity:		

Card details

Medicare Number:	Ref No:	Expiry:
Health Care Card:		Expiry:
Pensioner Concession Card:		Expiry:
DVA Card- Gold ☐ White ☐ No:		Expiry:
Do you consent to for your medical records to be uploaded on Myhealth record?		Yes ☐ No ☐

Relationship status

Single	Married	De Facto/Partner	Divorced	Widowed
Number of children:		Age of Children:		

Next of Kin

Name	Relationship to you
Mobile	Home
Is this person also your **Emergency Contact**? Yes / No	
If NO Name of Emergency contact:	Phone:
Relationship to you:	

Payer for children under 15 years of age (Parent to complete)

Name of parent (as listed on Medicare card)		
Parent Date of Birth: / /		
Parent Medicare number:	Ref No:	Expiry:

PTO →

Your Health History

Please list your current and regular medications including prescription, over the counter medications, vitamins and herbal medicines:

Allergies (Medications, other)

Smoking History	Alcohol
☐ Never	☐ Non Drinker
☐ Former smoker – quit / /	☐ Rarely/Light
☐ Current smoker - /day	☐ Moderate
☐ Number of years smoking	☐ Heavy

Do you engage in physical activities? No/Yes Details-

Do you use recreational drugs? No/ Yes Details-

Females only

Date of last Pap smear-

Date of Mammogram (if over 40)

Children Are immunisations up to date?

Please indicate whether you have experienced any of the following conditions

☐ High BP	☐ Migraines/Headaches	☐ Fluid Retention
☐ Heart Problems	☐ Fainting/Blackouts	☐ Problems with any organs
☐ Asthma/Lung Disease	☐ Vertigo	☐ Reproductive problems
☐ Seizure/Epilepsy	☐ Kidney Disease	☐ Pregnant (how many weeks)
☐ Tuberculosis	☐ Sciatica/Lumbago/Backpain	
☐ Thrombosis	☐ Cancer	☐ Can't get pregnant
☐ Haemophilia/bruising	☐ Heartburn/Reflux	☐ Skin Condition
☐ Stroke	☐ Joint pain/discomfort	☐ Diabetes
☐ Stress	☐ Varicose Veins	☐ Anxiety
☐ Constipation or Diarrhea	☐ HIV Positive/Aids	☐ Fatigue

Do you have any other diseases or conditions that you are aware of? Yes ☐ No ☐

If yes, please specify:

Family History

☐ Diabetes	☐ Breast Cancer
☐ High Blood pressure	☐ Stroke
☐ Heart Disease	☐ Cancer
☐ Depression/Mental Illness	☐ Arthritis
☐ Autoimmune disease	☐ Prostate cancer

We will communicate with you around various health related topics including preventive care, follow up health information and early case detection reminders and recalls. We utilise a variety of communication methods including post, phone, secure email and SMS.

Consent for Appointment reminders and Recalls by SMS:

☐ Yes, I wish to receive · No I do not wish to receive

How did you hear about us? (eg. website, Facebook) _____

Signed: _____

Date: _____/_____/_____