

<b>Wye Medical Centre</b> Shop 2 Wye Shopping Centre 131-133 Wye Rd, Wye 2259 Tel: 02 42114595 Fax: 02 42114594 Email: reception@wyeemmedicalcentre.com.au	<h1 style="margin: 0;">New Patient Registration Form</h1>
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We need this information to provide the best quality of care. This form complies with *RACGP Standards for general practices (5<sup>th</sup> edition)*. This means your personal 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 allows us to contact you promptly about tests and results.

<b>Personal Details</b>
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<b>Title:</b>	<b>First Name:</b>	<b>Middle Name:</b>	<b>Surname:</b>
	<b>Preferred Name:</b>		<b>Date of Birth:</b>

<b>Gender (please circle):</b>	Male	Female	Transgender	Different Identity
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<b>Pronouns (please circle):</b>	He/Him/His	She/Her/Hers/Herself	They/Them/Theirs
<b>Birth Gender:</b>	Male	Female	Other

<b>Marital Status (please circle):</b>	Single	Married	De Facto	Separated	Divorced	Widowed
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<b>Home Address:</b>	<b>Suburb:</b>
<b>State:</b>	<b>Postcode:</b>
<b>Same as postal address:</b> Yes / No    If No, Postal Address/PO Box:	

<b>Mobile Phone:</b>	<b>Home Phone:</b>
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<b>Email Address:</b>
<b>Occupation:</b>

**Cultural Background:** Knowing your background can help us provide a healthcare that better meets your individual needs.

Are you of Aboriginal or Torres Strait Islander Origin (please circle):	No	Yes (see below)
Aboriginal                      or                      Torres Strait Islander	or	Both

<b>Ethnicity:</b>	<b>Country of Birth:</b>
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<b>Is English your first language (please circle)</b>	Yes	or	<b>No (see Below)</b>
Do you require an interpreter?		Please state which language.	

<b>Next of Kin Name:</b>	Address:
Phone Number:	Relationship:

<b>Emergency Contact Name:</b>	Address:
Phone Number:	Relationship:

DVA Card ( <i>please circle</i> )    Gold   or   White    Number:		Expiry Date:						
Medicare Card No.		Ref no. ( <i>next to name</i> )	Expiry Date:					
Concession Card number:		Expiry date:						
Type of card: Healthcare (yellow & green)		Pension card (blue)						
Private Health fund ( <i>please circle the answer</i> )    Yes    or    No								
If yes, Fund Name:		Number:	Ref no.					
<b>Smoking/Vaping History</b> ( <i>please circle</i> ):								
Non Smoker	Smoker    Date started:	Per day:	Ex Smoker    Date ceased:					
<b>Vaping:</b> Yes    or    No								
<b>Do you use recreation drugs:</b> Yes    or    No		<b>If yes, specify:</b>						
<b>Alcohol History</b> ( <i>please circle</i> ):								
Non drinker	Ex Drinker    Date Ceased:	Drinker    Per Day/Days per week:						
<b>Health History and Family Health History</b> ( <i>please circle</i> ):								
	<b>Yourself</b>		<b>Mother</b>		<b>Father</b>		<b>Other Medical conditions/History:</b>	
<b>Diabetes</b>	yes	no	yes	no	yes	no		
<b>Asthma</b>	yes	no	yes	no	yes	no		
<b>Stroke</b>	yes	no	yes	no	yes	no		
<b>Heart Attack</b>	yes	no	yes	no	yes	no		
<b>Cancer</b>	yes	no	yes	no	yes	no		
<b>Allergies – yes /no</b> ( <i>if yes, please list</i> ):								
<b>Are you sensitive to medications or dressings?</b> No    Yes ( <i>see below</i> )								
<b>If yes, please specify nature of reaction:</b>								
<b>Consent</b>								
I consent to our practice using reminder systems to maintain your health. Our practice sends reminders by post, email, telephone or SMS for your appointments/ procedures.							Yes	No
I consent to the doctors at this practice utilising: - National/State reminder systems (e.g. cervical screening, immunisations); - Medical services (e.g.) My Health Records/PCEHR System (Shared Health Summary) - The Local Primary Health Network using Pen CS software which the practice shares deidentified patient health information to provide best patient care.							Yes	No
Our practice also sends information to the Australian Immunisation Register and Pap Smear Register. These registers also send reminders. You are under no obligation to provide consent to the use of your personal information. We will respect your wishes if you do not consent.								
I have read this form: <u>I understand it and I give my consent</u> Yes    No								
<b>Patient or Guardian's signature:</b> ..... <b>Date:</b> .....								