CLEAR ISLAND WATERS
HEALTH PRECINCT

Patient Registration Form

Title *Mr / Mrs / Miss / Ms / Master/_____*

Surname _____ First Name_____

Date of Birth _____ Preferred Name _____

Are you of Aboriginal Decent or Torres Strait Islander decent? 

☐ *No* ☐ *Yes - Aboriginal* ☐ *Yes – Torres Strait Islander* ☐ *Both*

Preferred language? English/Other _____ Nationality? Australian/Other _____

Address: _____

Suburb _____ Postcode _____

Telephone: Mobile _____ Home _____ Work _____

Email _____

Medicare Card Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No _____ Expiry_____

Pension Card Number _____ **Expiry** _____ **Aged** **Disability** **Other**

Healthcare Card Number (Centrelink) _____ Expiry _____

Dept of Veteran Affairs Card Number _____ Expiry _____

Occupation_____ Married De-Facto Single Widowed Divorced Separated

Next of Kin Name: _____Phone _____Relationship _____

Emergency Contact _____ Phone _____ Relationship _____

I hereby give express permission Clear Island Waters Health Precinct staff and Doctors to receive and supply Personal Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc on my behalf.
I acknowledge that I am wholly responsible to arrange further appointments to discuss test results conducted by my Doctor at all times.
I give permission to be notified by letter, phone, email or text message for all Recalls and Reminders.
I give consent to access the Pap Smear Register. - *If required.*

HIC Online, For Eligible Bulk Bill Patients
I hereby authorize Clear Island Waters Health Precinct to process my claim through Medicare Australia

Signed _____ **Dated** _____

Please tick if ☐ Parent ☐ Guardian

How did you hear about us? ***(Please tick)***

☐ Google Search ☐ Healthengine ☐ Website ☐ Facebook ☐ Family / Friend ☐ Walk Past ☐ Other

Please Turn over for New Patient Medical History Form to be filled in with relevant details.

New Patient Medical History Form

All information is kept private and confidential and will help our doctors to give you a better long term treatment plan for your health requirements.

Name_____D.O.B _____

Do you intend to use us as your regular GP? YES NO UNDECIDED

Current Height _____ Weight _____

Are you currently taking any medication?

_____

_____

Are you currently undergoing any medical treatment or any operations recently?

_____

Do you smoke please tick ☐ Never ☐ Yes – Cigarettes per day_____ ☐ I Quit Date_____

Alcohol Usage ☐ Never ☐ Days per week_____ Drinks per day _____
☐ Heavy drinker in the past

Are you allergic to any medication or materials? i.e Penicillin. Latex?

_____

Ladies, date of Last Pap Smear_____ Normal Abnormal Are you pregnant? N Y

Due date_____

	High/Low Blood Pressure		Heart attack/heart surgery		Contact with HIV/AIDS
	Hepatitis A,B,C		Diabetes Type 1 ☐ Type 2 ☐		Depression or mental illness

Have you ever had any of the following? Please tick those that apply on the left hand side.

	Back pain		Stroke		Asthma or Breathing Problems
	Artifical joint		Cancer		Diarrhoea or bowel trouble
	Other:				

Is there any Family History of Diabetes, Heart Disease, Tumours etc? (please give details):

_____

_____

_____