Gladstone Park Medical Clinic **Patient Registration / Information Form**

SURNAME / FAMILY NAME:			
GIVEN NAME:		INITIAL:	
PREFERRED NAME:			
TITLE:	MR MRS MISS MS OTHER: ……………	GENDER:	M F
DATE OF BIRTH:	……….. / ……..…. / ………..	Are you Aboriginal or Torres St Islander ?	Y N

ADDRESS: HOME		CONTACT DETAILS please indicate preferred contact number	
		HOME PH:	
		MOBILE PH:	
SUBURB:		WORK PH:	
POSTCODE:		EMAIL:	

ADDRESS: POSTAL		Is English your main language ?	
Only if different to the HOME address above		Yes No	
		If NO, what is your main language -	
SUBURB:		…………………………………………..	
POSTCODE:			

MEDICARE NUMBER		EXP DATE	
VETERAN AFFAIRS		EXP DATE	
HEALTH CARE CARD		EXP DATE	

NEXT OF KIN DETAILS		CONTACT DETAILS: NOK.	
SURNAME / FAMILY NAME		HOME PH:	
GIVEN NAME		MOBILE PH:	
RELATIONSHIP		WORK PH:	

EMERGENCY CONTACT			
NAME		PHONE	

Have you registered your EFT / Bank details with Medicare ? __ *Yes* __ *No*

Registration form available on our website

We routinely offer a recall / reminder service for YOUR HEALTH & WELL BEING -
(eg: skin checks, annual health reviews, pap smears, cholesterol check, etc.)
Please advise one of our staff if you do NOT wish to participate.

We routinely send Appointment reminders via SMS.
Please advise one of our staff if you do NOT wish to have reminders sent.

All information collected on this form is treated confidentially and in accordance with Privacy Regulations

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Is this consultation part of a Worker's Compensation and/or Motor Vehicle accident claim ? __ Yes __ No

If yes please provide insurer and claim number -

Insurer: ______________________________

Claim No: ______________________________

nb: - Until such time as we have an authorised claim number or acceptance from your insurer, you will be responsible for any fees incurred. Once your claim is accepted, your insurer will reimburse costs and all subsequent accounts relating to your claim will be forwarded to your insurer.

Do you wish to allow us to discuss and/or provide any of your medical details with a nominated person ?

Spouse ___ *Yes* ___ *No* *Mother* ___ *Yes* ___ *No*

Partner ___ *Yes* ___ *No* *Father* ___ *Yes* ___ *No*

Other: please specify ______________________________

Do you wish to provide a standing authority to allow a nominated person (e.g. - your child) to be billed using your credit card ?

If Yes, you can either complete details below or advise our staff when at the practice.

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiry Date: ____ / ____ *CSV:* __ __ __

Do you have Private Health Insurance ? ___ *Yes* ___ *No*

If Yes - Fund Name: ______________________________

Membership Number: ______________________________

Do you have another GP outside of this practice that you visit ?

If Yes – Drs Name: ______________________________

Surgery: ______________________________

Do you have any Allergies ? ___ *Yes* ___ *No*

If Yes - provide details: - ______________________________

____

Do you or have you ever smoked tobacco ?

Current smoker : _________

Previous smoker : _________

Never smoked : _________

If you are a New Patient to the practice, can you please let us know how you came to hear about GPMC.

Family Member: ____ *Friend:* ____ *Website:* ____ *Other:* ____

Thank you for providing the information on this form. This assists us in maintain accurate patient details.

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