Bremer Medical Centre

New Patient Registration Form

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.

Title	Dr Prof Mr Mrs Miss Ms Master		
Surname		**Date of birth**	/ /
First Name/s		**Gender**	☐ Male ☐ Female
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?** No ☐ Yes , Aboriginal ☐ Yes ,Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ **Other cultural background (e.g. 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: _____		
Occupation			
Street Address			
Suburb		**Postcode**	
Postal Address	☐ Same as above		
Home Phone		**Work Phone**	
Mobile Phone			
Email			
Medicare Card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Ref No. ___**	**Expiry Date ___ / ___**
Pensioner Card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry Date** ____ /____ /_____	
Health Care Card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry Date** ____ /____ /_____	
DVA ☐ Gold ☐ White	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry Date** ____ /____ /_____	
***OSHC/Student #** *(Overseas Health Care)		**Expiry Date** ____ /____ /_____	
Next of Kin	First Name: Surname: Phone: Relationship to you:		
Emergency contact?	First Name: Surname: Phone: Relationship to you:		

Allergies and medicines

List allergies and intolerances to medications	Describe your reaction

List regular medications and doses, and complementary medicines and doses

Relevant Past Medical history

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

Consent
Our practice uses a reminder system to help you maintain your health. The practice sends reminders by **post**, **email**, **phone** or **SMS** for procedures such as vaccinations, cervical screening, skin checks and other health reviews.

I consent to being contacted with reminders and health promotions to help me maintain my health.
Yes ☐ No ☐

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

Signature of patient or guardian: _____ Date : / /

How did you hear about our clinic?

☐ Friend / family ☐ Workplace ☐ USQ ☐ Social Media ☐ Google
☐ Online advert ☐ Newspaper / magazine advert ☐ Signage

☐ Other _____

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.