Dunn Bay Surgery

Patient Registration Form

This is information will be stored securely and used in your clinical file only.

Patient Information			
Title (circle)	**Mr Mrs Ms Miss Dr Other:**		
Surname			
First Name		**Middle Name**	
D.O.B.			
Gender	**Male Female Other: ________________________ Prefer not to say**		
Preferred Name (If different)			
Street Address			
Postal Address (If Different)			
Phone Number	**Home:** **Mobile:**		
Email			
Contact Method (preferred)	**Mobile Home Phone Email SMS**		

Emergency Contact			
Full Name:	**Contact Number:**	**Relationship:**	
Next of Kin:	**Contact Number**	**Relationship:**	
Healthcare Details			
Medicare Number ___________________	**Ref:**	**Expiry:**	**Medicare Gender:** _________________
DVA Gold/White	**Number:**	**Expiry:**	
Concession HCC/Pensioner	**Number:**	**Expiry:**	

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people of different nationalities please complete this section.

Country of Birth:	**Ethnicity:**
Do you speak language other than English? **No/Yes:**	**Do you require a translator?** **No/Yes**
To assist with Health Initiatives do you identify as any of the following? (circle)	**Aboriginal Torres Strait Islander Neither**

Signature____ Date_______/_________/__________

Dunn Bay Surgery

<table>
<tr><th colspan="4">Health Information</th></tr>
<tr><td colspan="4">Allergy Information:
Do you have any allergies or sensitivities to medications or dressings? No/Yes: Provide Details</td></tr>
<tr><td colspan="4">Current Medications: (including over the counter medication, vitamins, minerals, health supplements).</td></tr>
<tr><td colspan="4">Health History:</td></tr>
<tr><td colspan="4">Operation/s: No/Yes: (Give Details)</td></tr>
<tr><td colspan="2">Asthma: No/Yes</td><td colspan="2">Hypertension: No/Yes</td></tr>
<tr><td colspan="2">Diabetes: No/Yes</td><td colspan="2">Heart Disease: No/Yes</td></tr>
<tr><td colspan="2">Cancer/s: No/Yes: (provide details)</td><td colspan="2">Chronic Illnesses: No/Yes: (provide details)</td></tr>
<tr><td colspan="4">Other:</td></tr>
<tr><td colspan="4">Family History: Please circle if any of your family have had any of the following.</td></tr>
<tr><td colspan="2">Diabetes</td><td colspan="2">Asthma</td></tr>
<tr><td colspan="2">Cancer</td><td colspan="2">Heart Disease</td></tr>
<tr><td colspan="2">Hypertension</td><td colspan="2">Mental Illnesses</td></tr>
<tr><td colspan="4">Other:</td></tr>
<tr><td colspan="4">Social History</td></tr>
<tr><td>Smoking:</td><td>No:</td><td>Yes: _____/Day</td><td>Stopped:
Date_________</td></tr>
<tr><td>Alcohol:</td><td>No:</td><td colspan="2">Yes: ________/day __________/Week</td></tr>
</table>

Dunn Bay Surgery collects information for the purpose of providing high quality health care. All information disclosed is stored securely and in accordance to our Privacy Policies.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information for the following purposes.

- Administrative purposes in the operation of our practices
- Billing purposes, including Medicare requirements
- Disclosure to other health care professionals involved in your care
- Accreditation and quality assurance activities
- For legal related disclosure as required by a court of law
- To allow medical students and staff to participate in training where de-identified information is used
- To comply with legislative or regulatory requirements e.g., Notifiable diseases

I, ______________________, have read and understood the above information and give permission for my information to be used for the above purposes. I understand that if my information is to be used for any other purpose, my further consent will be obtained.

Signature__________________________________ Date ____/_____/_____