PRIVATE PATIENT REGISTRATION FORM

PATIENTS DETAILS

Title _____ First Name _____ Surname _____

D.O.B _____ Address _____ Suburb _____ Post code _____

Phone No: (H)_____ (W) _____ (M) _____

Email _____ Employer _____

Referrer's Name _____ Phone _____

Next of Kin or Parent/Guardian _____ Phone _____

Emergency Contact _____ Phone _____

TAC / Work Cover (circle) Claim No _____

Medicare No _____ Ref No _____ Expiry _____

Private Health Insurance YES NO If yes, name of fund _____ Membership No_____

Are you of Aboriginal or Torres Strait Island descent? NO/YES if yes _____

Pension, Health Care or Veterans Affair card No.(if applicable) _____ exp:_____

How did you hear about us? (please tick the box)

☐ **Word of Mouth** ☐ **Yellow Pages** ☐ **Google Search** ☐ **Health Fund**

☐ **Brochures** ☐ **Signage** ☐ **Employer** **Other** _____

CONSENT

I consent to the use of my personal health information by the Era Health and other health providers involved in my medical treatment and health care.

I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Our Practice uses a reminder system to improve the quality of your health care and to promote preventative health care. Our practice routinely sends out health related newsletters, reminder emails and we telephone and send SMS reminders for appointments and procedures including vaccinations, PAP tests and other health reviews. You may opt out of receiving any or all of these communications at any time.

CANCELLATION POLICY

We require at least 12 hours notice to cancel or change your appointment. Failure to give this notice may result in a cancellation fee of $70 being charged.

PAYMENT OF THE CANCELLATION FEE IS REQUIRED WITHIN 7 DAYS

I, _____ have read and understood the above condition of being a patient at this practice, and agree to pay the cancellation fee should I cancel without giving 12 hours notice. I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

_____ _____

Signature **Date**

FOR ERA HEALTH USE ONLY

ENTERED BY: **CHECKED BY:** **DATE:**

New Patient Health Questionnaire

"The questions below are asked to provide your doctor with information that can assist them in providing culturally appropriate, preventative and best practice medicine. All questions are optional"

Patient Name: _____ Date of Birth: / /

Do you identify with any specific cultural groups " YES /NO If yes_____"

Smoking
Have you ever smoked? Y N

Do you still smoke? Y N

If Yes, How many cigarettes per day do you smoke?_____

If No, When did you quit? _____

Would you like advice and support on how to quit smoking? Y N

Alcohol
Do you drink Alcohol? Y N _____

If yes, how many standard glasses of alcohol do you drink per day?

Would you like advice and support on reducing intake or quitting drinking alcohol? Y N

Women's Health
When was your last Pap smear? _____

Have you ever had a mammograms? Y N

If yes, when was the most recent mammogram taken? _____

Men's Health
If you are over 45 years old, have you ever been tested for prostate cancer? Y N N/A

General Health
In the past, have you ever suffered:

Shortness of breath / chest pain? Y N

High Blood Pressure? Y N

Are you diabetic? Y N

Depression or Anxiety Y N

Do you take any regular medications? _____

Do you have any known allergies? _____

Do you have a family history of Diabetes, Heart Conditions or Cancer?

Please understand that your responses to these questions may raise concerns for your consulting doctor. These issues may not be able to be addressed in a single appointment and your GP may