WEST BRUNSWICK CLINIC
Your health care team

Doctor	

New Patient Registration Form - Adult

Title (please circle)	Mr ◯ Mrs ◯ Ms ◯ Other:		Gender: ☐ Male ☐ Female Other:			
Surname						
First Name			Middle name			
Preferred name			Date of birth			
Unit/Street number		Street name				
Suburb				Postcode		
Postal address						
Mobile telephone			Home telephone			
Work telephone			Preferred contact:	Mobile/Work/Home ☐		
Occupation						
Email address						
Next of kin or	Name					
preferred contact	Telephone		Relationship			
Emergency contact	Name					
	Telephone		Relationship			
Legal guardian	Name					
(if applicable)	Telephone		Relationship			
Medicare number				Ref #	Exp date	
Pension card number					Exp date	
Healthcare card #					Exp date	
DVA Gold/White #					Exp date	

To assist with health initiatives are you: Aboriginal or Torres Strait Islander? (please circle)

NO ◯ **YES - Aboriginal & Torres Strait Islander** ◯ **YES** - Aboriginal ◯ **YES** - Torres Strait Islander ◯

Nationality/Culture		Country of Birth	
Preferred language		Do you require an Interpreter?	YES NO

Communications Consent
I consent to receive SMS messages as ticked below

Appointments ☐ Clinical Reminders ☐ Clinical Communications eg recall test results ☐ Health Awareness eg Wellness information ☐

For further information please refer to our communication policy on our website at www.wbc.com.au

Privacy

Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times in accordance with privacy laws, and to ensure that this information about how the practice handles your record is available to you upon request. Our practice undertakes professional development and quality assurance improvement activities to improve patient care.

I acknowledge that information provided on this registration form is true and accurate.

Signature of patient		**Date**	/ /

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Medical History

Please provide details of your medical history including any operations and hospitalisations

Year/Onset	Details

Medications

List all the medications you are taking (prescriptions, over the counter or herbal)

NO current Medications (please tick) ☐

Medication	Dosage	How often taken	Medication	Dosage	How often taken

Allergies & Intolerances to Medications

Do you have any allegies or intolerances to medications?

allergies or intolerances (please tick) **YES** ☐ **NO** ☐

Allergies to Medications	Type of Reaction	Other Allergies	Type of Reaction

Family History

Have any of your family members been diagnosed with any of the following significant health conditions?:

HEART DISEASE		RESPIRATORY DISEASE		ASTHMA	
DIABETES		KIDNEY DISEASE		CANCER	
OTHER					

Smoking & Alcohol

Do you smoke?	☐ YES	☐ NO
How many cigarettes per day?		
Did you ever smoke?	☐ YES	NO ☐

Do you drink alcohol?	☐ YES	☐ NO
How many days per week?		
How many drinks per day?		