WEST BRUNSWICK CLINIC

Your health care team

Dr	

Title (please tick)	☐ Mr ☐ Mrs ☐ Ms ☐ Mx ☐ Other:			
Gender (please tick)	☐ Male ☐ Female ☐ Non-Binary ☐ Other:			
Pronouns	☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Zirs			
Surname				
First Name		**Middle Name**		
Preferred Name		**Date of Birth**		
Address				
Suburb		**Postcode**		
Postal Address				
Mobile Telephone		**Home Telephone**		
Work Telephone		**Preferred Contact**	☐ M ☐ H ☐ W	
Occupation				
Email Address				
Next of Kin or Preferred Contact	*Name*			
	Telephone		*Relationship*	
Emergency Contact	*Name*			
	Telephone		*Relationship*	
Legal Guardian (if applicable)	*Name*			
	Telephone		*Relationship*	
Medicare Number		*Ref #*	*Expiry Date*	
Pension/HCC Card #			*Expiry Date*	
Card Type (please tick)	☐ Pensioner Concession ☐ Healthcare Card ☐ Commonwealth Seniors Card			
DVA Number		☐ Gold ☐ White	*Expiry Date*	

To assist with health initiatives are you: Aboriginal or Torres Strait Islander?

☐ 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 ☐ Health Awareness eg Wellness Information

For further information, please refer to our ommunciation policy on our website at www.wbc.net.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***	

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)

*Please tick if you are **not** currently taking medications* ☐

Medication	Dosage	Medication	Dosage

Allergies to Medications

Do you have any allergies to medications? ☐ Yes (list below) ☐ No

Allergy	Type of Reaction	Allergy	Type of Reaction

Family History

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

Condition	☐	Who & Details	Condition	☐	Who & Details
Heart Disease	☐		***Diabetes***	☐	
Respiratory Disease	☐		***Kidney Disease***	☐	
Asthma	☐		***Cancer***	☐	
Other Family History (please list if applicable)					

Other Information/Conditions

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?		