Shop 2/44 Robinson Road, Seaford Heights SA 5169
Phone: 08 8185 7160
Fax: 08 8212 2567
admin@seafordheightsmc.com.au

New Patient Registration Form

SECTION A: Personal details

Title (please tick)	Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other…..............
Birth sex (please tick)	Female ☐ Male ☐ Other……………..
Gender identity (please tick) Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Other ……………	
Pronouns (please tick)	She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Given Names:	Surname:
Date of Birth:	Known as:

Street address:
Suburb and Postcode:
Postal address:

Home Phone:	Work Phone:
Mobile Phone:	Email:

Occupation:

Medicare Card no:	Ref no:	Expiry:

Do you have: Pension card ☐ Health Care card ☐ DVA ☐ No concession ☐

Card number______________________________________ Expiry____________________

DVA card colour: Gold ☐ White ☐

Next of Kin:	
Phone no:	Relationship to you:
Emergency Contact:	
Phone no:	Relationship to you:

Do you identify as: Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐

If yes, do you consent to be registered for CTG: Yes ☐ No ☐

Nonspeaking English background Yes ☐ No ☐

If yes, please specify…………………………………...

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SECTION B: Consent

SMS reminders
I consent to being contacted with appointment reminders, recalls and health awareness information

Yes ☐ No ☐

Signature:	Date:

We are a private billing practice. Children under 16 and DVA card holders are bulk billed. To all other patients, there is a cost involved. Full payment of your account is required on the day of your consultation, the Medicare rebate will be refunded into your bank account within 24hours. Work Cover and Motor Vehicle Accident appointments require payment in full on the day. No accounts will be issued, unless you have a current claim number. Please sign below you have read and understood this.

Signature:	Date:

SECTION C: Medical History

MEDICATIONS*: please include all therapeutics e.g. vitamins, minerals, supplements and any other medications*

ALLERGIES AND/OR ADVERSE REACTIONS:

IMMUNISATIONS: please tick

Childhood vaccinations up-to-date ☐ Pneumococcal ☐ Influenza ☐ Tetanus ☐

Others……………………………………………….

LIFESTYLE:

Current weight………………kg **Current height.**…………cm **Waist measurement** .... cm

Smoking: Never ☐ Quit ☐ Year quit………… Currently ☐ Smoke………/day

Alcohol: Yes ☐ if yes, days per week ……. standard drinks per day…….. No ☐

SIGNIFICANT FAMILY HISTORY:

No significant family history ☐ or,

Mother: Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Depression ☐ Breast cancer ☐

Father: Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Depression ☐ Breast cancer ☐

Privacy
In accordance with the Privacy Act (1988), all information collected in this practice is treated as “sensitive information”. To protect your privacy, this practice operates in accordance with the Act. We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone numbers etc. Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. – radiology, pathology services).
Please note – due to privacy laws it is preferred that adults over sixteen years of age arrange their own appointments whenever possible.
Results cannot be given to a third party, except under special circumstances.