CRANE ROAD MEDICAL CENTRE – CASTLE HILL

Please assist us by completing all details on this **New Patient Registration Form** and present it to our staff with your **Medicare Card** and **valid Photo ID**. Please notify us promptly of any changes in your contact details so we can contact you promptly about tests and results.

<table>
<tr><th colspan="3">New Patient Registration Form</th></tr>
<tr><td colspan="3">1. Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Dr ☐
Family name: .... First name: ....</td></tr>
<tr><td>2. Date of Birth: ____ / ____ / ____</td><td colspan="2">3. Sex: M ☐ F ☐ Other ☐ Unknown ☐</td></tr>
<tr><td>4. Home Address:</td><td>Suburb:</td><td>Postcode:</td></tr>
<tr><td>5. Postal Address:
(or Same As Above)</td><td>Suburb:</td><td>Postcode:</td></tr>
<tr><td>6. Mobile ph:</td><td>Home ph:</td><td>Work ph:</td></tr>
<tr><td colspan="3">7. E-mail:</td></tr>
<tr><td colspan="3">8. Medicare No:.. Ref No on card: 1 2 3 4 5 Expiry: ____ / ____</td></tr>
<tr><td colspan="3">9. Concession card: (please tick) None ☐ Pension ☐ HCC ☐
Concession card No: .... Expiry: ___ / ____</td></tr>
<tr><td>10. DVA card No: ....</td><td colspan="2">Colour: (please circle) Gold / White / Orange</td></tr>
<tr><td>11.Emergency contact details</td><td colspan="2">12. Next of kin contact details
(☐ tick if same as emergency contact)</td></tr>
<tr><td>Name:</td><td colspan="2">Name:</td></tr>
<tr><td>Address:</td><td colspan="2">Address:</td></tr>
<tr><td>Phone:</td><td colspan="2">Phone:</td></tr>
<tr><td>Relationship to you:</td><td colspan="2">Relationship to you:</td></tr>
<tr><td colspan="3">13. Ethnicity: (please tick) Australian ☐ English ☐ Chinese ☐ Indian ☐ Other ☐ (specify) ______
To help with health initiatives, Are you of Aboriginal or Torres Strait Islander origin?
Yes Aboriginal ☐ Yes Torres Strait Islander ☐ Yes Both ☐ No ☐</td></tr>
</table>

Patient Consent:

(1) I give permission for my medical records and personal health information to be shared between the doctors of the practice for the purpose of my medical care.

(2) I authorise Crane Road Medical Centre to access and upload my shared health summary to My Health Record.

(3) I agree to allow my doctor to communicate relevant medical information to specialists, hospital staff, pathology labs and other health care providers involved in my medical care.

(4) Our practice provides our patients with preventative care and early case detection reminders, e.g.-immunisation, skin checks, annual health checks, pap smears etc. So I give my consent to being contacted with reminders

(5) I give my consent to being contacted as part of our recall systems for the follow up of investigations results.
*Please note, if you say **NO** you are responsible for booking follow up appointments to obtain your test results.

(6) I give my consent to being contacted/reminded of appointment via SMS.

Signature:.. Date:..

(Office Use Only)	**Entered by - Staff Name:**	**Date:**

CRANE ROAD MEDICAL CENTRE - CASTLE HILL

Medical Health Summary

CONFIDENTIAL – Please give this section to your Doctor only

Name:	**Date of Birth:**

What is the reason for today's visit?

Current Medical Conditions: (Do you have any current long - term conditions? (e.g.- heart disease, diabetes, cancer, asthma, eczema, high blood pressure etc)

Past Medical Conditions: (e.g.- fracture, surgery, appendectomy, etc)

Medications: (Please state any tablets or medicines you take include over the counter,herbal and contraceptive medications)

Name	Dose	Reason

Allergies: Do you have any allergies or sensitivity to drugs or dressings? **Yes/No**

If **Yes** Please list:

Family History (Have any of your parents, brothers or sisters had the following)

Mother alive? ☐ Yes ☐ No	☐ Diabetes ☐ Depression ☐ Breast Cancer	☐ Heart attack ☐ ☐ Migraine ☐ ☐ Hypertension	☐ Stroke ☐ Asthma ☐ Melanoma	☐ Bowel Cancer ☐ Other Information ....
Father alive? ☐ Yes ☐ No	☐ Diabetes ☐ Depression ☐Prostate Cancer	☐ Heart attack ☐ Migraine ☐ Hypertension	☐ Stroke ☐ Asthma ☐ Melanoma	☐ Bowel Cancer ☐ Other Information ....

Social

Marital status	**Advance Care Directive**	**Enduring Power of attorney**	**Accommodation**	**Lives with**
☐ Single ☐ Married ☐ Defacto ☐ Seperated ☐ Divorced ☐Widowed	☐ Yes ☐ No	☐ Yes ☐ No	☐ Own home ☐ Relative s home ☐ Other Private Home ☐ Hostel ☐ Nursing Home ☐ Homeless ☐ Rental home	☐ Spouse ☐ Relative ☐ Friend ☐ Alone

Occupation:

Alcohol	☐ Non drinker	☐ Drinker Days per week: ____ Standard drinks per day: ___	Past alcohol intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy Yr started: _____ Yr stopped: _____	
Smoking	☐ Non smoker	☐ Ex smoker Past smoking history: ☐ Light ☐ Moderate ☐ Heavy Yr started: ________ Yr stopped: ________	☐ Smoker Amount per day: _______	
Exercise	☐ Nil	☐ Regular Exercise	☐ Moderate Exercise	☐ Elite Athlete