CESSNOCK MEDICAL CENTRE

Cessnock Surgery Pty Ltd, trading as Cessnock Medical Centre

Patient Registration and Consent Form

| 204 Wollombi Road, Cessnock, NSW, 2325 | P: 02 4990 5600 | F: 02 4991 4004 |

Filling in this form:
* Print in BLOCK LETTERS
* Mark boxes like this ☐ with a ✔ or ✗

Patient details

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following:

1 Dr ☐ Mr ☐ Mst ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

2 Family name:

3 First given name:

4 Date of birth: / /

5 Gender: Male: ☐ Female: ☐ Transgender: ☐ Other: ☐ please specify:

6 Medicare card number: Ref No:

7 Do you have a Pension or Healthcare card?:
No: ☐
Yes: ☐ - if yes, what is your Customer Reference No:

8 Do you have a Dept. of Veterans Affairs (DVA) card?:
No: ☐
Yes: ☐ - if yes, what is your DVA No:
Gold DVA card: ☐
White DVA card: ☐
Orange DVA card: ☐

9 Home address:

Postcode:

10 Postal address (if different to above):

Postcode:

11 Home phone number:

12 Mobile phone number:

13 Work phone number:

14 Email:

15 To assist with health initiatives, please indicate your Ethnicity?
Australian: ☐
Aboriginal: ☐
Torres Strait Islander: ☐
Other: ☐ please specify:

Your health history

16 Do you have any allergies or adverse reactions?:
No: ☐
Yes: ☐

If yes, please indicate allergy & adverse reaction below:

1)
Adverse reaction:- Mild: ☐ Moderate: ☐ Severe: ☐ Life Threatening: ☐

2)
Adverse reaction:- Mild: ☐ Moderate: ☐ Severe: ☐ Life Threatening: ☐

3)
Adverse reaction:- Mild: ☐ Moderate: ☐ Severe: ☐ Life Threatening: ☐

4)
Adverse reaction:- Mild: ☐ Moderate: ☐ Severe: ☐ Life Threatening: ☐

17 Height: cm *(if known)* Weight: kg *(if known)*

18 Do you have a history of: *(tick applicable)*
Asthma: ☐ approx. Date of diagnosis: / /
Diabetes: ☐ approx. Date of diagnosis: / /
Hypertension: ☐ approx. Date of diagnosis: / /
Depression: ☐ approx. Date of diagnosis: / /
Other: ☐ please specify:

Your social history

19 How often do you smoke cigarettes and/or vapes?:

Never: ☐

Daily: ☐

Less than weekly: ☐

Weekly: ☐

Ex-smoker: ☐ approx. date you ceased:

20 How many cigarettes do you smoker per day:

21 How often do you drink alcohol?:

Never: ☐

Daily: ☐

1-2 days a week: ☐

1-2 days a month: ☐

Less than monthly: ☐

22 How many drinks containing alcohol do you drink per day:

23 Are you concerned about drinking? Yes: ☐ No: ☐ Don't know: ☐

Physical activity

24 How many times a week do you usually do 20 minutes of vigorous physical activity that makes you sweat or puff and pant?
(*Eg: jogging, running, swimming, bike riding or aerobics)*

0: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐

25 How many times a week do you usually do 30 minutes of brisk walking or moderate physical activity that increases your heart rate or makes you breathe harder than normal?
(Eg: digging in the garden, dancing, golf or tennis)

0: ☐ 1: ☐ 2: ☐ 3: ☐ 4: ☐ 5: ☐ 6: ☐ 7: ☐

Your family history

26 Is your mother alive? ☐ Yes ☐ No ☐ Don't know

27 If no, what age was she when she died

28 Is your father alive? ☐ Yes ☐ No ☐ Don't know

29 If no, what age was he when he died

30 Did either of your parents have any of the following? *(please circle)*

Heart disease, Diabetes, Stroke, Hypertension,
Breast cancer, Colon cancer, Depression or Anxiety.

31 Do any of your other relatives have any of the above conditions? If yes, which disease? What relationship is the relative to you?

Next of Kin / Emergency Contact

32 Family name:

33 First given name:

34 Phone number:

35 Relationship to next of kin / emergency contact:
Parent: ☐ Partner or Spouse: ☐ Child: ☐ Friend: ☐ Other Relative: ☐

Patient declaration

36 I acknowledge and consent that:

- The doctors and staff at Cessnock Medical Centre may contact me by post, sms and/or telephone, in regards to results or correspondence.
- The doctors and staff at Cessnock Medical Centre may contact me by sms or post, in regards to recalls and reminders for immunisations, health screenings or health assessments etc.
- I am responsible for booking and attending any specialist or allied health appointments the doctor refers me to. If I am unable to attend these appointments, I agree to notify the relevant parties to cancel and/or reschedule the appointment.
- I will contact the practice to follow up the results of any tests or investigations the doctor requests me to complete.

I declare that:

- The information I have provided in this form is complete and correct.

Patient **or** parent/guardian's full name:

Patient **or** parent/guardian's signature:

Date:

/ /