

PATIENT REGISTRATION

This information remains strictly confidential and will not be shared with a third party unless for the immediate purposes of providing healthcare, instructions by a court of law, prevention of a serious threat to a person's life, or with your written consent. Please see our privacy policy for more details.

Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other:		
Surname		First Name:	Preferred:
Date of Birth			
Street Address			
Postal Address			
Phone	Home:	Mobile:	Work:
Email			
Occupation			
Medicare Number		Ref No.	Expiry:
DVA	Gold <input type="checkbox"/> White <input type="checkbox"/>	Number:	
Centrelink	Pension Number: Expiry:	Health Care Card Number: Expiry:	

Next of Kin		Relationship:
Phone		
Emergency Contact		Relationship:
Phone		

Nationality		Do you require a translator? Yes <input type="checkbox"/> No <input type="checkbox"/>
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To assist with health initiatives do you identify as Aboriginal or Torres Strait Islander?

Aboriginal: Yes <input type="checkbox"/> No <input type="checkbox"/>	Torres Strait Islander: Yes <input type="checkbox"/> No <input type="checkbox"/>	Aboriginal & Torres Strait Islander:
Are you an Interstate or Overseas visitor to Adelaide?	Yes <input type="checkbox"/> No <input type="checkbox"/> *if yes please note full fee is payable today for your consult	
Do you intend to have ongoing medical care provided by O'Halloran Medical Centre? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Would you like reminders sent via sms for: appointments, test result recalls, upcoming preventive medicine reminders such as pap smears & health checks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you like our clinical staff to upload an ehealth summary to your MyGov account?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes Identifier no.

Do you wish to nominate another person who we can speak to on your behalf regarding upcoming appointments or your medical care? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If Yes	Name:	Relationship:

Office Use Only. Dr: _____ Staff: _____ Nurse: _____

PATIENT NAME: DATE OF BIRTH:

Our practice provides our patients with preventive care and early case detection reminders
e.g.: - immunisations, annual health checks; skin checks and pap smears.

Do you offer consent to participate? Yes No

Important Medical History eg chronic diseases, cardiac, cancer etc	Please list:
Do you have any Allergies to medications or wound dressings?	Yes <input type="checkbox"/> No <input type="checkbox"/> Nil known <input type="checkbox"/> If yes please list:

Social history:

Marital Status: Single Married DeFacto Separated/divorced Widow/er

In order to offer a complete health service, do you identify as LGBTIQA? Yes No

Please state: _____

Are you an Elite Athlete Yes No

Do you have an Advanced Care Directive in place Yes No

Do you have a Carer Yes No

Current Occupation: _____

Australian Defence Force Current Permanent Current Reserves Past Permanent or Reserves

Alcohol:

Non Drinker Alcohol: Type _____

How many days per week: _____ how many standard drinks per day: _____

Past Alcohol Intake: Nil Occasional Moderate Heavy Year started: _____ Year Stopped: _____

Tobacco:

Non Smoker Ex Smoker Year started: _____ Year stopped: _____ Light Heavy Moderate

Smoker: type ie cigarettes, pipe, cigar _____ year started: _____

Recreational Drug use: _____ (type and frequency)

Family history:

Mother still alive: yes No Age at death: _____ reason of death: _____

Father still alive: yes No Age at death: _____ reason of death: _____

Significant family history

Mother: Diabetes Hypertension Heart disease Stroke

Colon cancer Depression Breast cancer

Father: Diabetes Hypertension Heart disease Stroke

Colon cancer Depression

Females: When did you last have a -

Pap smear: Date _____ not sure never

Breast Check: Date _____ not sure never

Mammogram: Date _____ not sure never

Males: When did you last have a -

Full check up: Date _____ not sure never

For those 65 years and older: when was the last time you were immunised for -

Influenza: Date _____ not sure never

Pneumococcal: Date _____ not sure never

Is there any other information that you believe we should know that may affect / or have an influence on the medical treatment / advice you will be provided with?

If Yes, please provide details below -

Signature: Date: / /

Thank you for your cooperation and please return your completed form to your GP.

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Website: www.ohalloranmedical.com.au