Dr Timothy Ong
Dr John Hanrahan
Dr Daniel Kim
Dr Hollie Speake

QUEENS PARK MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Patient Details:

Title ____ Given Names _____Surname _____(Preferred Name) _____

Date of Birth:____/____/_____ **Gender**: **Male** ☐ **Female** ☐

Ethnicity: _____

Country of Birth: _____

Year arrived in Australia: _____

Does the patient require a translator? **Yes/no**

If yes, please indicate which language:

_____

Are you of Aboriginal or Torres Strait Islander origin?

Yes ☐ No ☐

If, yes, please specify below:

Aboriginal ☐

Torres Strait Islander ☐

Aboriginal & Torres Strait Islander ☐

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ **Ref No** ☐

Expiry date: ☐☐ ☐☐

Concession Type: Pension Card ☐ **Health Care Card** ☐ **Veteran Affair** ☐

Card Number: ☐☐☐☐☐☐☐☐☐ Letter ☐

Expiry date: ☐☐ ☐☐ ☐☐

Patient's home Address: _____

Suburb: _____ **Postcode:** ☐☐☐☐

Phone: Home) _____ **Work) _____**

Mobile: _____ **Occupation: _____**

Email: _____

Marital Status: Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorce ☐ Widowed ☐

Next of Kin

Given Name: _____Surname:_____Relationship to you_____

Phone :(Home)_____(Work)_____(Mobile)_____

Emergency Contact – write '**AS ABOVE'** if next of kin and emergency contact are the same person.

Given Name: _____Surname:_____Relationship to you_____

Phone :(Home)_____(Work)_____(Mobile)_____

Patient's Height: _____ cms Weight: _____kilos Waist : _____ cms

Non-Smoker ☐ Ex-Smoker ☐ Smoker: ☐

If smoker How often: _____ No. of cigarettes: _____

Alcohol: No ☐ Yes ☐ How often: _____

No of standard drinks _____ in a day /week/month

Allergies if any:

_____

_____

How did you find out about us?

Internet Family/Friend Newspaper
Drove by Other:

I consent for the practice to contact me via SMS for appointment reminders, recalls and other test reminders or medical services we offer
Yes / No

Information

To provide high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of the information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound to confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

Signature of patient or guardian _____ Date ___/____/_____