Dr Timothy Ong
Dr Daniel Kim
Dr Hollie Speake
Dr Isabelle Teo
Dr Merilyn Lam
Dr Lakmal Nandadewa
Dr Amrick Banwaith

QUEENS PARK MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Patient Details:

Title ____ Given Names _____Surname _____(Preferred Name) _____

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

Ethnicity: _____

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: ☐☐ ☐☐ ☐☐

OSHC/OVHC Membership Number: ☐☐☐☐☐☐☐☐

Patient Number ☐☐

Card Number (BUPA cardholders)

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Allergies: Yes / No /Nil Known
If yes, please specify details

_____
_____
_____
_____
_____
_____
_____

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

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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***

Failure to Attend Policy:

By signing the form, you acknowledge the following:

- I am responsible to attend the appointment and if I am unable to do so, it is also my responsibility to notify the practice that I am unable to attend my appointment.
- An automated SMS will be sent to me the day prior to my appointment and I am responsible to respond 'Yes' or 'No' to inform the practice on my attendance.
- If I am unable to attend an appointment, I will give **at least** 2 hours notice to the practice of cancellation of my appointment to ensure that other patients have a chance of seeing the GP.
- If I fail to attend my appointment, I may be charged a failure to attend fee.

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 providers 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 ___/____/_____