

NEW PATIENT REGISTRATION FORM

Welcome to Casey Family Practice

To assist us in ensuring your personal information is correct, please complete the following details. Once completed, please hand this to the receptionist with your Medicare Card and Pension Card or Health Care Card if you have one.

We look forward to providing you with quality medical care.

NAME: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss _____	
ADDRESS: _____	
POST CODE: _____	
DATE OF BIRTH: / / _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Do you identify as an ABORIGINAL OR TORRES STRAIGHT ISLANDER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SMOKER: <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOME PHONE NO: _____	MOBILE: _____
WORK PHONE NO: _____	OCCUPATION: _____
EMERGENCY CONTACT: _____	PHONE NUMBER: _____
MEDICARE CARD NO: _____	EXPIRY DATE: / / _____
PENSIONER CARD NO: _____	
HEALTHCARE CARD NO: _____	EXPIRY DATE: / / _____
VETERANS AFFAIRS CARD: _____	TYPE: <input type="checkbox"/> GOLD <input type="checkbox"/> WHITE <input type="checkbox"/> ORANGE
ALLERGIES: _____	
CURRENT MEDICATIONS: _____	
FAMILY HISTORY: _____	
PAST MEDICAL HISTORY: _____	
Email (if you like us to send news & information): _____	

YOUR PRIVACY AND MEDICAL INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management. All information is de-identified. If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all times your health information is treated with utmost confidentiality.

I have read and understood the above information regarding my medical information.

SIGNATURE OF PATIENT: _____

DATE: / / _____