SWANSEA
CHANNEL PRACTICE

NEW PATIENT REGISTRATION FORM A

Dear Patient
Swansea Channel Practice is committed to providing patients with the best possible care. To do this it is essential that your medical records are accurate.
We require the following information to complete our files. All information provided will be handled with the utmost privacy and confidentiality.

Surname Please Circle **(Mr Mrs Ms Miss Mst)**
Marital Status:

Given Names:

Date of Birth: **Country of Birth**

Street Address:

Suburb and Post Code:

Telephone Home:

Work:

Mobile:

Email:

Occupation:

Are you of Aboriginal or Torres Strait Islander descent? **Yes/No**

Preferred Language Other than English:

Emergency Contact:
Phone:
Relationship to you:
Do you give permission for messages to be left with this contact on your behalf?
Yes/No

SIGNATURE: DATE::

Medicare Card Number **Expiry Date**
__ __ __ __ __ __ __ __ __ __ **Ref No:** __ ___/___

DVA **Expiry Date**

Pension Number **Expiry Date**

For Electronic Medicare Claiming

Name of Bank:

Account No:

BSB:

P.T.O.

MEDICAL HISTORY

Do you have any allergies? Yes/No

If yes please list:

Family Medical History? (Please Circle)	Asthma Yes /No	Cancer Yes /No	Diabetes Yes/No
	Heart Attack Yes/No	Stroke Yes/No	Other
Your Medical History Do you have/ or ever had?	Asthma Yes /No	Cancer Yes /No	Diabetes Yes/No
	Heart Attack Yes/No	Stroke Yes/No	Other
Please circle appropriate response:	Smoker	Former smoker Quit Date	Non Smoker
If you smoke or a former smoker how many cigarettes a day do/did you smoke?			
Do you Drink Alcohol? Please circle:	Less than monthly	1-2 Days a month	1-2 Days a week
	3-4 Days a week	5-6 Days a week	Every day

How many standard drinks would you have in one day?

Current Medications: (including dosage)

Do you ever take over the counter Medication/ Minerals or Vitamins on a daily basis? Yes/No

If yes please list:

For those **65 years and older**: When was the last time you were immunised?

Influenza	Date_____	Not Sure/ Never
Pneumococcal pneumonia	Date_____	Not Sure/ Never
Females: When did you last have?		
Pap Smear	Date_____	Not Sure/ Never
Breast Check	Date_____	Not Sure/ Never
Males: When did you last have?		
An overall check up	Date_____	Not SureNever

Consent Declaration:

I, ... hereby consent to Swansea Channel Practice, transferring this information to other Health Providers to aid in my ongoing medical care and management, and at times understand that it made be used in Statistical Data for Practice Enhancements within the Swansea Channel Practice.

Signature:.....Date:.....

Should I decide to leave Swansea Channel Practice I understand that there will be an administration fee of $33.00 for the downloading and transferring of medical records.