BAY MEDICAL CENTRE NEW PATIENT REGISTRATION FORM

Mr Mrs Miss Ms Other Child M/F	**FIRST NAME:**	**MIDDLE NAME:**	**SURNAME:**

DATE OF BIRTH	**COUNTRY OF BIRTH**	**MARITAL STATUS**	**OCCUPATION**

DRIVERS LICENCE FOR PHOTO ID (Photo ID MUST be provided. Please be aware that some medications will not be supplied without photo identification)

TICK (✓) PREFERRED CONTACT

MOBILE PHONE: _____ HOME PHONE: _____ EMAIL: _____

TICK (✓) CONSENT TO RECEIVE SMS

RESIDENTIAL ADDRESS: **POSTAL ADDRESS:**

MEDICARE NUMBER **Ref No.** **Expiry date**

Current concession cards MUST be presented on arrival

PENSION OR HEALTH CARE CARD No. **Expiry Date**

DVA GOLD CARD NO.

NEXT OF KIN – NAME: PHONE No.

Relationship to patient:

EMERGENCY CONTACT – NAME: PHONE No.

Relationship to patient:

DO YOU IDENTIFY AS:	**YES**	**NO**
Aboriginal Origin		
Torres Strait Origin		
Aboriginal and Torres Strait Origin		
Other Culture: **Please Specify**		

DO YOU HAVE A REGULAR GP ELSEWHERE? YES NO

Please provide details

ALLERGIES: Do you have any allergies? If so, please list allergies and reaction(s):

Alcohol Status: number of drinks/day ( )

Smoking Status how many cigarettes/day ( )

Medications: do you take any regular medications, if YES please list or advise your Doctor

Any significant family history: please provide details

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Asthma	Diabetes
Cancer	Heart Disease

Other: please provide details

The GPs at Bay Medical Centre bulk bill for patients with a current Medicare Card, however work-related injury or illness will attract a separate fee structure and is NOT claimable from Medicare. Please ask our Receptionist for more information regarding fees etc.

NO RESULTS ARE GIVEN OUT OVER THE PHONE: An appointment is required with your Doctor to discuss results

APPOINTMENTS ARE REQUIRED FOR ALL REPEAT PRESCRIPTIONS – NO EXCEPTIONS

Pathology, Radiology and Specialist Investigations will attract separate fees from the individual providers.

The Practice uses a reminder/recall system for results and preventative care. Please indicate below if you DO NOT wish to receive reminders.

I DO NOT WISH TO RECEIVE REMINDERS/RECALLS FROM THIS PRACTICE (Please tick) ☐

When you register as a patient of this practice, you provide consent for our GP's and practice staff to access and use your personal information to provide you with the best possible health care. Only staff who need to see this information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do so.

The Doctors of this Practice endeavor to give all patients as much time as necessary. Unfortunately, delays are sometimes unavoidable, particularly in times of emergency or when serious or unexpected situations arise. Priority is always given to these cases and we ask for your understanding and co-operation when this occurs. You can assist us by rescheduling your appointment if you are unable to attend. If you have several or complex issues to discuss, please ask for a long appointment.

Please sign and date below to indicate that you have read and acknowledge the above.

Patients Name: (please print) ……

Name of Parent/Guardian (please print) ……

Patients/Parent/Guardian's
Signature……Date ……