SOUTHERN REGIONAL MEDICAL GROUP

New Patient Registration Form

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practice. This means your personal health information is kept private and secure as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any change in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you about tests and results.

Section A: **Personal Details**

Title **Surname** **Given Names**

Date of Birth **Gender** **Medicare Card No.** **Position No.** **Expiry Date**

/ / Male Female / /

Pension or Veterans Affairs Card no. (if applicable) **Type of Concession Card** **Expiry Date**

/ /

Occupation

Home Address **Postcode**

Postal Address *(if different to Home Address)* **Postcode**

Telephone Number **Work Number** **Mobile Number**

Email

Who can we contact in case of an emergency?

Name **Relationship to you**

Telephone number **Work number** **Mobile number**

Next of Kin ***(mandatory for all patients under 16 years of age)***

Name **Relationship to you**

Telephone number **Work number** **Mobile number**

Do you have an advance health directive for end of life care?

Yes **No**

For more information, please talk to your GP.

32 Albany Highway, Albany WA 6330 (t): 08 9845 9000 (f): 08 9842 1233
Appointments can be booked online at: www.srmg.com.au

SOUTHERN REGIONAL MEDICAL GROUP

Section B: **Cultural Background**

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐

Other Cultural Background *(eg. Mediterranean, African, Asian)*

Country of Birth

Is English your first language?

Yes ☐ No ☐

If not, do you require an interpreter?

Please specify language

Section C: **Consent**

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap recalls and other health reviews.

Our practice also sends information to the Australian Immunisation Register and Pap Smear Register. These registers also send reminders which can be helpful if you move.

I consent to being contacted with reminders to help me maintain my health.

Yes ☐ No ☐

Signature of patient or guardian

Date

/ /

Section D: **Transfer of Health Information**

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact information or Medicare details change.

Office Use Only:

IS THIS PATIENT A MINOR?	**YES**	☐	**NO**	☐
IF YES, ARE THE PARENT/ LEGAL GAURDIAN DETAILS RECORDED *(Next of Kin)*?	**YES**	☐	**NO**	☐
ARE ALL THE DETAILS ENTERED ON PRACSOFT?	**YES**	☐	**NO**	☐

INITIAL: _____ **DATE:** _____/_____/_____