New Patient Registration Form

Darwin Children's Clinic

We need this information to provide the best quality care. This form complies with the RACGP *standards for general practices.* This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have any concerns, please leave blank and discuss with your Doctor. Please notify us promptly of any changes in your contact details. Accurate contact details helps us identify you and your medical records, and allows us to contact you promptly about tests and results.

Section A **: Personal Details**

Title_____ Surname_____ Given Names_____

Date of Birth_____ Gender_____

Marital Status *Please circle*
Single Married Defacto Separated Divorced Widowed

Medicare Number_____ Reference_____Exp_____

Pension, Health Care Card, or Veterans Affairs Number *(if applicable)*

Occupation_____

Home Address_____

Postal Address_____

Telephone Numbers

Home_____ Work_____ Mobile_____

Email_____

Who can we contact in an emergency?

Name_____ Relationship to you_____

Telephone Numbers

Home_____ Work_____ Mobile_____

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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? *Please circle*

No Yes, Aboriginal Yes, Torres Strait Islander

Yes, Both Aboriginal & Torres Strait Islander

Other Cultural Background (eg Mediterranean, Asian, African)

Is English your first language? **If not do you require and interpretor?**

Yes / No Yes / No

Please specify Language_____

Section C: **Allergies and Medicines**

List allergies and intolerances to medications

Describe your reactions

List regular medications and doses, and complementary medicines and doses

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Section D : **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 6 week checks, 6 month reviews, results and other health reviews.

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

Yes / No **Signature of Patient or Guardian**_____

Date: _____

Section E: **Transfer of health information**
You may have consistently consulted with a GP/Doctor at another practice. The information held by that Doctor may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health 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.