PFGP
PENINSULA FAMILY GENERAL PRACTICE

PATIENT REGISTRATION FORM

The Doctors and Staff at this clinic are committed to whole patient care. This includes preventative and ongoing care. To assist us maintain your wellbeing we ask you to complete this form. All information collected about you will remain confidential.

Title: _____ **First Name**: _____**Family Name:** _____

Preferred Name/ Known as: _____ **Gender:** _____

Date of Birth: _____/_____/_____

Address: _____**Suburb:** _____**Postcode:** __ __ __ __

Home Phone: _____**Mobile:** _____

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Ref Number (This is the number next your name): ___ **Expiry**: _____

DVA (Veteran Affairs) Gold/White: _____ **Expiry:** _____

Pension/Health Care Card number:_____ **Expiry:**_____

Emergency Contact/Next of Kin

Contact Person's First Name: _____**Family Name:** _____

Relationship:_____**Phone:** _____

Are you Aboriginal? Yes / No
Are you Torres Strait Islander? Yes / No **Ethnicity/Country of Birth**: _____

PRIVACY
We must obtain your consent for messages to be left on your telephone or mobile answering or message bank regarding matters involving your health. Do you agree? **YES/ NO**

REMINDER SYSTEM
Our practice provides our patients with preventative care and early case detection reminders eg: immunisations, health assessments, skin checks and cervical screening tests. **Do you agree for reminders to be sent to you by SMS and mail YES / NO?**

CONSENT
I authorise Peninsula Family General Practice to collect, discuss and provide ongoing management and care with other health providers directly or indirectly involved in my personal health care or medical treatment.

Name:_____ **Signature:**_____ **Date:**_____

Please list any Allergies:

_____ Reaction: _____

_____ Reaction**:** _____

Please list any operations/previous illness/current medications

_____

_____

Have you ever had or have any of the conditions below? If "Yes" please circle

Diabetes Kidney disease Asthma Bowel Cancer Breast Cancer High Blood Pressure Heart Problems Epilepsy

Other:_____

Significant family history: please circle below

Mother: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Breast Cancer

Father: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression Breast Cancer

Comment: _____

Marital Status: _____ Who do you live with? _____

How many children do you have? ____ Occupation: _____

Please fill out what applies to you below 'please circle below'

Current alcohol intake

Non drinker

Days per week: _____ Standard drinks per day: _____

Comment: _____

Past alcohol intake

Nil Occasional Moderate Heavy

Year started:_____ Year stopped:_____

Comment:_____

Current smoking history

Non Smoker Ex Smoker Smoker

Cigarettes per day:_____ Year started:_____ Year stopped:_____

Drug use Yes/ No

If Yes: Type_____ Frequency _____

Weight _____kg Height_____cm

Name:_____**Signature:**_____ **Date:**_____