Bairnsdale Family Practice & Skin Cancer Clinic

New Patient Registration Form

SURNAME		**MS MRS MR DR**
GIVEN NAME(S)	PREFERRED NAME	
DATE OF BIRTH		
RESIDENTIAL ADDRESS		
POSTAL ADDRESS		
MOBILE PHONE	HOME PHONE	WORK PHONE
MEDICARE NUMBER	**Ref No.**	**Expiry Date**
DVA NUMBER	**Gold / White** *(Please Circle)*	**Expiry Date**
CONCESSION CARD NUMBER	**(PLEASE CIRCLE) Pension OR Health Care Card**	**Expiry Date**
OCCUPATION	**EMAIL**	
EMERGENCY CONTACT:	DO YOU GIVE PERMISSION FOR US TO CONTACT THIS PERSON IN AN EMERGENCY OR IN THE EVENT THAT WE CANNOT CONTACT YOU? **YES**	**NO**
NAME		
PHONE NUMBER	RELATIONSHIP TO PATIENT	
NEXT OF KIN:	DO YOU GIVE PERMISSION FOR US TO CONTACT THIS PERSON IN AN EMERGENCY OR IN THE EVENT THAT WE CANNOT CONTACT YOU? **YES**	**NO**
NAME		
PHONE NUMBER	RELATIONSHIP TO PATIENT	

DO YOU IDENTIFY AS BEING OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT? (PLEASE CIRCLE)	
NO	YES – TORRES STRAIT ISLANDER
YES – ABORIGINAL	YES – ABORIGINAL and TORRES STRAIT ISLANDER
IF YES, ARE YOU REGISTERED FOR THE CLOSING THE GAP PROGRAM	YES NO
OTHER ETHNICITY?	**COUNTRY OF BIRTH?**
PREFERRED LANGUAGE:	
NAME OF PREVIOUS MEDICAL CENTRE:	
DO YOU REQUIRE YOUR RECORDS TO BE TRANSFERRED FROM YOUR PREVIOUS MEDICAL PRACTICE? (IF YES, YOU WILL NEED TO SIGN AN AUTHORITY, *PLEASE* SEE RECEPTION) _ **YES NO**	
TELEPHONE:	FAX:
YOUR MEDICAL HISTORY:	**DATE:**
GPMP (GP MANAGEMENT PLAN FOR CHRONIC DISEASE)	
HEALTH ASSESSMENT	
MENTAL HEALTH PLAN	
ANY ALLERGIES?	**REACTION(S)**
DO YOU CONSENT TO HAVE YOUR RECORDS SENT TO "MY HEALTH RECORD"	**YES NO**

I HEREBY CONSENT TO BEING A PATIENT AT BFP AND I CONFIRM THAT I AGREE TO OBSERVE ALL THE PRACTICE'S POLICIES AND PROCEDURES.

SIGNATURE: _____ **DATE:** _____/_____/_____