Hamilton Medical Centre
41 Nudgee Road, HAMILTON QLD 4007 (Tel: 07 3268 7411, Fax: 07 3868 2063)

NEW PATIENT REGISTRATION FORM

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Dr

FIRST NAME: …… SURNAME: ……..

ADDRESS: ……

DATE OF BIRTH: …… ORIGINAL NATIONALITY/ETHNICITY: ……..

Do you identify as Aboriginal and/or Torres Strait Islander? No ☐ Yes ☐

MOBILE: …….. PHONE (HOME): ……

Job and organisation: ……..

MEDICARE CARD NO: …….. Line number: …… EXPIRY: ……..

PENSION CARD/HCC NO: …… EXPIRY: ……

DVA CARD NO: …… Gold ☐ White ☐ Orange ☐

EMERGENCY CONTACT: ……

Relationship to you: …… Phone: ……..

Allergies: …….. Smoker?: Yes/No/Ex → (quit date:……)

Please list any medical history and past surgery/operations/previous illness/injuries:

……

……

Do you take regular medications? No ☐ Yes ☐ If yes, please list below:

……

……

Any family history of diseases? No ☐ Yes ☐ If yes, please list who and what condition/s below:

……

This practice operates in accordance with the Privacy Act (1988) and all information collected in this practice is treated as "sensitive information". We use the information you provide to manage your healthcare. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number, Medicare details etc. Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. pathology & radiology). Please tick below:

☐ I consent to the use of my personal health information by Hamilton Medical Centre and other health providers involved in my medical treatment and health care directly or indirectly (includes My Health Record/PCEHR).

☐ In case of an emergency, I consent to Hamilton Medical Centre contacting the emergency contact person I have listed.

I have read the Practice Information and agree with the terms and conditions. Please obtain a copy of our Practice Information from our receptionists or visit our website.

Signature: _____ Date: _____/_____/_____