# WERRIBEE MEDICAL CENTRE

Accredited General Practice

## PATIENT REGISTRATION FORM

**Werribee Medical Centre is committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate. Your personal information is kept private and secure, as required by privacy laws.**

### Patient Details:

Title: _____ Surname: _____ First / Given Names: _____

Date of Birth: _____/_____/_____ Gender: Male ☐ Female ☐ Other ☐ _____

Preferred Pronouns (Optional): _____

Country of Birth: _____ Do you speak English? Yes ☐ No ☐

If you require an interpreter for this consultation, please advise language required: _____

Home Address: _____

Phone: (Home): _____ Work: _____ Mobile: _____

Mobile preferred contact for home/ work? Yes ☐ No ☐

Email: _____

Marital Status: Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation: _____ Employer: _____

### Next of Kin:

Surname: _____ First Name: _____ Relationship to You: _____

Phone: (Home): _____ Work: _____ Mobile: _____

### Emergency Contact:

Is the person you listed as your Next of Kin, also your emergency contact: Yes ☐ No ☐

If not, please list your emergency contact details below:

Name: _____ Relationship to you: _____

Phone: (Home): _____ Work: _____ Mobile: _____

### Health Card Details:

Medicare Number: _____ Reference No:( ) Expiry Date: _____/_____/_____

Pension / HCC: _____ Expiry Date: ____/_____/_____

Veteran's Affairs Number: _____ Expiry Date: ____/_____/_____

Private Insurance Fund: _____

### Cultural Background and Health Initiatives:

Australia is genuinely a multicultural society. To tailor care, encourage understanding and appreciation between people from different nationalities and backgrounds, do you identify as someone from a culturally, ethnically and / or linguistic diverse background?

Yes ☐ No ☐ If yes, please elaborate_____

To assist us with health initiatives do you identify as being:

Aboriginal origin ☐ Torres Strait Islander origin ☐ Both ☐ Neither ☐

## Patient Health History:

Height(cm): _____ Weight(kg): _____

Do you have any allergies and intolerances to any drugs or dressings? Yes ☐ No ☐

Please give details: _____

Are you taking regular medications and /or over the counter medications? Yes ☐ No ☐

Please give details: _____

## Past Medical History:

Do you have or have you had a history of the following? (please give details:)

Diabetes: Yes ☐ Details: _____

Asthma: Yes ☐ Details: _____

Cancer: Yes ☐ Details: _____

Chronic Kidney disease: Yes ☐ Details: _____

Respiratory disease: Yes ☐ Details: _____

Cardiovascular disease: Yes ☐ Details: _____
(High blood pressure, High cholesterol, Heart attack, Stroke or TIA, (+/- coronary bypass / stent):

Other: Yes ☐ Details: _____

Immunisation History:

An up to date record of your current immunisation status is valuable medical information.

If you are completing this form for a child, are their immunisations up to date? Yes ☐ No ☐

If you are 65 years or older, have you been immunised for:

Influenza: Yes ☐ No ☐ Unsure ☐ Date of immunisation: ___/_____/_____

Pneumococcal: Yes ☐ No ☐ Unsure ☐ Date of immunisation: ___/_____/_____

Vaccine History: Have you had the following immunisations? List the date where Appropriate

| | | | | | |
|---|---|---|---|---|---|
| Tetanus Booster: | Yes ☐ | Date: ____/____/____ | Hepatitis A: | Yes ☐ | Date: ____/_____/____ |
| Gardasil: | Yes ☐ | Date: ____/____/____ | Hepatitis B: | Yes ☐ | Date: ____/_____/____ |
| Pneumococcal: | Yes ☐ | Date: ____/____/____ | Chicken Pox: | Yes ☐ | Date: ____/_____/____ |
| Influenza: | Yes ☐ | Date: ____/____/____ | Polio: | Yes ☐ | Date: ____/_____/____ |
| Meningococcal: | Yes ☐ | Date: ____/____/____ | COVID: | Yes ☐ | Date: ____/_____/____ |

**Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.**

**I consent to my health record being reviewed as a part of the quality improvement activities in this practice. Yes ☐ No ☐**

**Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap smears and other health reviews.**

**I consent to being contacted with reminders. Yes ☐ No ☐**

**Signature of patient or guardian** _____ **Date:** ____ **/** ____**/** _____

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

**Transfer of Health Information**
You may have consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for more information.