



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: _____

Ethnic / 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.