WEST CESSNOCK MEDICAL PRACTICE
100 Wollombi Rd Cessnock NSW 2325
Phone:02 4991 5550 Fax: 02 4991 5558
Email: contact@westcessnockmedicalpractice.com.au

New Patient Registration Form

Welcome to West Cessnock Medical Practice. Please ensure you read this form carefully and complete all sections. If you require help completing this form please ask one of our friendly staff.

*** The Privacy Act requires we provide patients with the option of not identifying themselves, or of using a pseudonym, when dealing with us. Please speak with our reception staff and we will organise for you to meet with our Admin. Manager to organise this. ***

YOUR DETAILS		
Title:	**Surname:**	**First Name:**
Date of Birth:	**Age:**	**Preferred Name:**
Gender Identity: **Female / Male / Transgender / Nonbinary / Gender Diverse / Other**	**Birth Sex:** **Female / Male**	**Pronouns:** **He/Him She/Her Them/They**
Country of Birth:	**Occupation:**	**Do you identify as Aboriginal and/or Torres Strait Islander?** **Yes / No**
YOUR CONTACT DETAILS		
Home Address:		
Suburb:	**Post code:**	**State:**
Mobile Ph:	**Home Ph:**	**Work Ph:**
Email: ****Please note we do not share your email address with any third parties or marketing groups****		
MEDICARE DETAILS		
Medicare Card Number:	**Reference Number:**	**Expiry Date:**
Pension/ Concession Card Number:	**Expiry Date:**	**DVA Card Number:** **Gold / White / Orange**
RELATIONSHIP STATUS: Single Married De Facto Separated Divorced Widowed Other:		
NEXT OF KIN DETAILS		
Name:	**Relationship to you:**	**Contact Numbers:**
EMERGENCY CONTACT DETAILS (if different from above)		
Name:	**Relationship to you:**	**Contact Numbers:**

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MEDICAL HISTORY		
Smoking: **Never**	**Former Smoker**	**Current Smoker**
	Quit Date:	***Packs per day:***
Number of years smoking (if applicable):		
Alcohol: If current or casual drinker please fill out your standard drinks per week		
Non-Drinker	**Former Drinker**	**Current Drinker**
	Quit Date:	***Drinks per week:***

Allergies	**Allergies**	**Allergies**
Allergies To:	**Allergies To:**	**Allergies To:**
Reaction Type:	**Reaction Type:**	**Reaction Type:**
Severity of reaction:	**Severity of reaction:**	**Severity of reaction:**

Please initial the following to indicate you understand and consent to West Cessnock Medical Practice procedures:

Patient Privacy Information: When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare. Only staff who need to see your personal information will have access to it. All persons accessing your records are bound by our Confidentiality Policy. If we need to use your information for anything else, we may seek additional consent from you to do this. This includes requests from 3rd parties including insurance and legal companies. All medical practices must adhere to mandatory reporting legislation. _____ ★

My Health Record: West Cessnock Medical Practice uses My Health Record to access and upload relevant health reports and summaries for patients. You will be asked by your GP for consent before any health summaries are uploaded. _____ ★

De-identified Data: As part of our responsibilities to Medicare we provide de-identified summarised data about various populations or groups. This information contains NO personal details that could identify you. _____ ★

Recall Appointments, Reminders and Messages: I consent to West Cessnock Medical Practice contacting me via phone, SMS, email or posted mail. In the event of West Cessnock Medical Practice being unable to contact me I understand they may contact my emergency contact. _____ ★

Medicare: We may use your information to check your eligibility and details with Medicare via the PRODA. I understand West Cessnock Medical Practice will send my billing directly to Medicare. _____ ★

Name: _____ Date: _____

Signature: _____ (parent if under 15 years of age)

Please speak with reception to have your medical records from your previous practice(s). Please be aware some medical practices may charge you for transferring your records.