FRASER SHORES MEDICAL CENTRE

HERVEY BAY SKIN

NEW PATIENT REGISTRATION FORM

☐ Mr ☐ Mrs ☐ Ms ☐ Miss	First Name:	Surname:
Preferred Name:		Date of Birth:
Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say ☐ Another gender (please specify) _____		Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal & Torres Strait Islander ☐ Prefer not to say
Country of Birth:		

Street Address:	Home Phone:
Postal Address:	Mobile Phone: Do you consent to receiving SMS reminders: ☐ Yes ☐ No
Email:	Occupation:

Medicare Number	☐☐☐☐☐☐☐☐☐☐ ☐ Ref	Expiry
Concession / Pension Card		Expiry

Next of Kin (NOK) Full Name: Address: Ph: Relationship:	Emergency Contact ☐ Same as NOK Full Name: Address: Ph: Relationship:

Do you have any allergies or are you sensitive to drugs or dressings?
☐ No ☐ Yes (please describe)

Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Prefer not to say

Living Arrangements: ☐ I live alone ☐ Partner/Spouse ☐ Children ☐ Parents ☐ Other family members
☐ Housemates / shared accommodation ☐ Residential aged care ☐ Prefer not to say
☐ Supported accommodation / group home ☐ Other (please specify) _____

Alcohol: ☐ Non-Drinker ☐ Drinker - Days per week: _____ Drinks per day: _____
Smoking: ☐ Non-smoker ☐ Ex-smoker ☐ Smoker - Smokes per day: _____

Significant Family History:
Mother: Alive - ☐ Yes ☐ No ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer ☐ Other _____
Father: Alive - ☐ Yes ☐ No ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Other _____

For patients under the age of 18:
Is a parenting order in place in relation to this child? ☐ Yes ☐ No
Are there any other court orders in place in relation to this child, e.g. a personal violence order? ☐ Yes ☐ No
If yes, please provide a copy of the order/s either in hardcopy or reception@frasershoresmedical.com.au

Important Disclosure: ALL MUST BE TICKED AND AGREED TO
☐ I have read and understand the laminated privacy statement at the back of this clipboard.
☐ I understand this clinic will not discuss any results over the phone.
☐ All patients MUST return to the clinic for test results.

Do you give consent for Electronic Health Record Collection ☐ Yes ☐ No

Patient / Guardian Signature: _____ Date: _____