Shop 3/ 120 Woogaroo St
Forest Lake QLD 4078.
Ph: 3279 9333
Fax: 3319 0978

NEW PATIENT REGISTRATION FORM

Title: Mr/ Mrs/ Ms/ Miss/ Mast **Sex:** Male/ Female/ Other **Ethnicity:** Aboriginal/ Torres Strait Islander/ Both / Other ________________________

First name: ______________________ **Surname:** _______________________ **Middle Name:** _______________ **Preferred Name:** _______________

Date of Birth: ___/ ___ / _____ **Country of Birth:** ________________________ **Occupation:** _________________

Mobile:______________ **Home Phone**:_____________ **Work Phone:** _______________**Email:** ____

Address: _________________________________ **Suburb:** ______________ **State:** _________ **Post Code:** ________

Do you consent to SMS recalls/reminders? Yes / NO

Medicare No: __ __ __ __ __ __ __ __ __ __ **Reference (___) Expiry Date:** ___ /______ **Private Health No**: ___________ **Provider** ______

DVA No: ______________**Type of Card - PLEASE CIRCLE:** GOLD / WHITE / ORANGE

PLEASE CIRCLE: Pension/Health Care Card **No:** _________________________ **Expiry Date:** ___/ ___/ _____

EMERGENCY CONTACT/ NEXT OF KIN

Title: ______ **First name:** ______________ **Last Name:** ______________ **Contact Number:** _______________ **Relationship to you:** ______________

ALLERGIES:
(PLEASE CIRCLE) Nil Known / Yes - ____

Do you smoke? No/ Yes _____ / day

Do you drink alcohol? No/ Yes - how many___/ week?

Do you have a family history of? (PLEASE CIRCLE) (M = Mother F = Father)

CANCER	M	F	STROKE	M	F
DIABETES	M	F	DEPRESSION	M	F
HEART DISEASE	M	F	HYPERTENSION	M	F

Patient Privacy Consent

I Certify that the above information is true and correct and authorise this practice to contact my nominated next of kin if warranted. I take responsibility for notification of any change to my contact details.

I have read the information on the next page and understand the reasons why my information must be collected. I am aware that Horizon Family Doctors has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but my failure to do so might compromise the quality of health care treatment. I am aware of my right to access the information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient/ Guardian Signature: ____ **Date:** ___ / ___ / _____