Brecken Health
BUILT TO CARE

Patient Registration

Please complete all sections

Please circle: Mr Mrs Ms Miss Master Other:

First Name: **Surname:**

Preferred Name: **Date of Birth:**

Occupation: Birth Sex: Female / Male / Other / Unknown

Gender Identity: Female / Male / Non-Binary / Gender Diverse / Transgender /Other:

Pronouns: she/her/hers he/him/his they/them/theirs

Health Insurance Provider: **Health Insurance Number:**

Address:

Suburb: **Postcode:**

Home Number: **Work Number:**

Mobile:

Email Address:

Country of Birth: **Ethnicity:**

Language spoken (if other than English)

Are you of Aboriginal or Torres Strait Islander Origin: Yes / No

Medicare Card Number:

Line Number (next to your name): **Expiry:**

Centrelink HCC Number: **Expiry:**

Centrelink PENSION Number: **Expiry:**

DVA Card Number: **Expiry:**

Next of Kin Name:

Address:

Relationship to You: **Phone Number:**

Emergency Contact Name: (tick if same as above ☐)

Address:

Relationship to You: **Phone Number:**

Name of Last Doctor / Surgery:

Do you have any allergies? if yes, please list:

Preferred Contact: Email / SMS / Letter **Do you wish to receive SMS appointment reminders: YES / NO**

Prescriptions: Paper Copy / Email Token / SMS Token

How did you hear about us? Please tick all that apply:

☐ Word of mouth ☐ Internet search ☐ Emergency Dept. ☐ Newspaper ☐ Signage
☐ Chemist ☐ Radio ☐ Television ☐ Referral ☐ Corporate Medical

Have you read and understood the privacy policy and fee structure? YES NO

This is located on the laminated forms attached to the clipboard

Please note we are a private billing practice

I understand the above Medical Practice complies with the Privacy Act (1988) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand that I have the right to request access to my information except where access would be denied and that the above Medical Practice makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for the above Medical Practice to use and disclose my personal information (except when legal obligations must be met).

My signature below indicates that I have read the above and consent to: (cross out what is not relevant)

- The above Medical Practice collecting, using, storing and disposing of my personal information
- The release of relevant information by the above Medical Practice to other health professionals (e.g. specialist, pathologist)
- Inclusion in a recall register to be advised of follow up visits, medical updates and health information
- Contact by the practice via electronic means (including but not limited to mobile phone, SMS, email and internet)
- The release of relevant personal information to my employer, their authorized representatives and their insurer in the case of a work related consultation or service
- I understand that all accounts must be paid at the time of the consulation

Signature **Date**

Please turn over for Medical Questionnaire

Brecken Health
BUILT TO CARE

NEW PATIENT QUESTIONNAIRE

This brief questionnaire will help the doctor assess you at your first appointment.
Please complete while you are waiting for your doctor.

Patient Name:_____ **Date of Birth:** _____

MEDICAL HISTORY

Do you have any pre-existing conditions you think your doctor may need to know about? Eg: asthma, diabetes, epilepsy, cancer, heart disease, high blood pressure, and so on.

FAMILY HISTORY

Are there any health problems that run in your family that you think the doctor should know about? Eg: cancer of any type, heart diseases and so on.

MEDICATION

Are you taking any medication? ❑ Yes ❑ No

If yes, please list below:

ALLERGIES

Tick more than one box if true

❑ I have no known allergies	❑ I get hay-fever/eczema/asthma
❑ I am allergic to:	❑ I carry adrenaline (Eg: Epipen)
❑ Severity: Mild / Moderate / Severe	❑ Nature of Reaction:

SMOKING

Do you smoke? ❑ Yes ❑ No	If yes how many a day?

If yes, How old were you when you started?

If you used to smoke how old were you when you gave up permanently?

Are you interested in quitting smoking?

ALCOHOL

Do you drink alcohol ❑ Yes ❑ No If yes, how many units per week?

VACCINATION/IMMUNISATION

When was your last Tetanus injection?

For children, are immunisations up to date?	❑ Yes ❑ No

MEDICAL SCREENING- If applicable, When were the following tests carried out.

For Women		
Pap smear	Mammogram	Cholesterol & Glucose Checks
For Men		
Prostate Check	Cholesterol & Glucose Checks	

I accept and acknowledge that I have answered the above questions correctly.

Patient Signature: **Date:**