Riverside Medical Centre

6299 6633

reception@riversidemedicalcentre.com.au

Patient registration form

Name

Prefix | First Name | Last Name

Date of birth

Day Month Year

Gender

- Male
- Female
- Transgender

Phone number

Area code | Phone number

Mobile number

Area code | Phone number

Work number

Area code | Phone number

Address

Street address

Street address 2

City | State / province

Postal code

Email

example@example.com.au

Occupation

Medicare number

Medicare ref.

Medicare expiry

Department of Veteran's Affairs

- DVA Gold
- DVA White

DVA number

Concession card number

Expiry

Next of Kin - Name

First Name Last Name

Emergency contact - Name

First Name Last Name

Next of Kin - Phone number

Area Code Phone Number

Emergency contact - Phone number

Area Code Phone Number

Next of kin - Relationship to you

Emergency contact - Relationship

Patient background

- ◯ Aboriginal
- ◯ Aboriginal & Torres Strait Islander
- ◯ I choose not to identify
- ◯ Torres Strait Islander
- ◯ Australian
- ◯ Other - please give details

How would you like reminders sent to you?

- ◯ Mail
- ◯ Email
- ◯ SMS
- ◯ Opt out

How would you prefer us to contact you?

- ◯ Home phone
- ◯ Mobile
- ◯ Email
- ◯ Mail

Do you have any allergies?

Please give substance, and reactions

Are you taking any medications?

Please give medication name and dose

Medical history

- [ ] Asthma
- [ ] Diabetes
- [ ] Hypertension
- [ ] Chronic illness
- [ ] Other

Details of any surgeries you've had

Smoking

- ◯ Nil
- ◯ Ceased
- ◯ Yes

How many per day

Alcohol

- ◯ None
- ◯ Occasional
- ◯ Moderate
- ◯ Heavy

Recreational / illicit drug use

- ◯ Nil
- ◯ Yes

Type

Frequency

Family history

Heart disease

- [ ] Mother
- [ ] Father

Mental illness

- [ ] Mother
- [ ] Father

Diabetes

- [ ] Mother
- [ ] Father

Asthma

- [ ] Mother
- [ ] Father

Hypertension

- [ ] Mother
- [ ] Father

Cancer

- [ ] Mother
- [ ] Father

Type

Your full name

- [ ] I hereby declare that the above information is true and accurate

- ◯ Patient
- ◯ Guardian

Date

Day Month Year