

New Patient Registration

Please complete in block letters. Fields marked * are required.

1. Your details

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other: _____
First name *	
Middle name	
Surname *	
Preferred name	
Date of birth *	___ / ___ / _____
Sex at birth *	☐ Male ☐ Female ☐ Another term: _____
Gender identity (optional)	
Pronouns (optional)	☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____
Country of birth	
Occupation	

2. Contact and Medicare details

Residential address *	Street address: Suburb: _____ State: _____ Postcode: _____
Postal address	☐ Same as residential or:
Mobile *	
Home / work phone	
Email	
Preferred contact	☐ SMS ☐ Phone call ☐ Email
Medicare number *	Number: _____ Ref no.: ____ Expiry: ____ / ____
Name on Medicare card	
Concession card	☐ Pension ☐ Health Care ☐ Commonwealth Seniors Card no.: _____ Expiry: ____ / ____
DVA card	☐ Gold ☐ White ☐ Orange Number: _____
Private health fund	

3. Next of kin, emergency contact and background

First person we should contact: ☐ Next of kin ☐ Emergency contact ☐ Same person for both

	NEXT OF KIN	EMERGENCY CONTACT
Full name		
Relationship to you		
Phone		
Address		

Interpreter needed?	☐ No ☐ Yes - language: _____
Aboriginal / Torres Strait Islander	☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both
Other cultural background	

4. Health history

For any "Yes", please give details.

Question	No	Yes	Details
Allergies or reactions (medicines, foods, latex)	☐	☐	
Current medications (incl. supplements)	☐	☐	
Operations or hospital admissions	☐	☐	
Asthma or other lung condition	☐	☐	
Diabetes	☐	☐	
High blood pressure	☐	☐	
Heart disease or stroke	☐	☐	
Mental health condition	☐	☐	
Other chronic illness	☐	☐	
Vaccinations in the last 10 years	☐	☐	
Smoke or vape	☐	☐	Amount:
Drink alcohol	☐	☐	Average per week:
Recreational drugs	☐	☐	Type / frequency:

Other relevant history, family history or concerns you would like to discuss:

5. Reminders, billing and consent

Health reminders. We send reminders for immunisations, health checks, skin checks and cervical screening. Would you like reminders by SMS, phone or mail? ☐ Yes ☐ No

Billing. Bunbury City GP bulk-bills eligible Medicare card holders. Please bring your Medicare card to every appointment.

Consent. I confirm the information on this form is correct. I consent to my relevant health information being shared between the general practitioners, nurses, specialists, allied health providers and practice staff involved in my care, for the purpose of managing my health. I understand it will be used to plan and provide my health care.

Patient signature (or parent / guardian if under 18)	
Print name	
Date	___ / ___ / ____

OFFICE USE ONLY ☐ Medicare checked ☐ ID sighted ☐ Entered in Best Practice Staff initials: _____