Stratford Medical Centre

NEW PATIENT REGISTRATION FORM

Preferred Title:	□ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed		
Name			
Date of Birth	**Sex at Birth:** □ Female □ Male		
Gender Identity	□ Female □ Male □ Non-binary □ Gender Diverse □ Transgender □ Different Identity Pronouns: □ She/Her/Hers □ He/Him/His □ They/Them/Theirs		
Nationality			
Do you identify as	□ Aboriginal □ Torres Strait Islander □ Both Aboriginal and Torres Strait Islander		
Street Address			
Postal Address			
Mobile	**Home**	**Work**	
Occupation	**Employer**		
Email Address			
Medicare Number		**IRN**	**Expiry Date**
DVA Gold / White			**Expiry Date**
Pension Card **Health Care Card**			**Expiry Date**
Next of Kin	**Name**		**Relationship**
	Phone number		
Emergency Contact	**Name**		**Relationship**
	Phone number		
Height:	**Weight:**		
Allergies: ☐**NO** ☐ **YES (**If yes, please list)			
☐ **Non-smoker** ☐ **Smoker** ☐ **Ex- Smoker** How many cigarettes per day? _____ Year started: _____ Year quit: _____			
Alcohol: How many days per week? _____ How many drinks per day? _____			
Significant family history: _____ _____ ☐ No significant family history ☐ Unknown (e.g. Adopted)			

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Stratford Medical Centre participates in Quality Improvement involving the sending of de-identification information for Health Data. Please inform reception if you do not wish to participate.

Privacy

Your medical record is a confidential document. It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff.
Please refer to our Privacy Policy located at Reception or via our website.

Do you consent to the Doctors at Stratford Medical Centre uploading and accessing your My Health Record?

☐ Yes ☐ No

Do you consent to receive SMS from your GP or Stratford Medical Centre regarding your appointments?

Appointment reminders	☐ Yes	☐ No
Clinical Reminders	☐ Yes	☐ No
Clinical Communications (Results & Clinical Messages)	☐ Yes	☐ No
Health Awareness (Leaflets & Database)	☐ Yes	☐ No

Do you consent to the Staff at Stratford Medical Centre sending unencrypted emails to you and service providers which may contain private/clinical information?

☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____

Photo ID sighted ☐ Staff Signed: _____