NORTHSIDE
FAMILY DOCTORS

New Patient Registration

Please complete all applicable fields. You can type into this PDF or print and write clearly.

01 Patient details

Legal first name(s)

Surname

Preferred name / pronouns (optional)

Date of birth (DD / MM / YYYY)

Sex recorded at birth (optional)

Gender identity (optional)

Residential address

Suburb / town

State / postcode

Postal address (if different)

Mobile phone

Other phone

Email address

02 Emergency contact

Contact name

Relationship to patient

Contact phone

Parent / guardian name (if applicable)

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Patient identification, communication preferences and information to support your care.

Patient full name

Date of birth

03 Medicare and concession details

Medicare card number

Individual reference number / expiry date

Concession card type / number (if applicable)

Concession expiry date

DVA card type / number (if applicable)

Usual GP / previous practice

04 Communication and support

Preferred contact method (tick one)

Mobile call SMS Email Post

May we send appointment reminders by SMS?

Yes No

May we contact you about preventive health reminders?

Yes No

Preferred language

Interpreter required? (Yes / No)

Accessibility or communication support needed (optional)

Do you identify as Aboriginal and/or Torres Strait Islander?

Aboriginal Torres Strait Islander Both

Alternatively:

Neither Prefer not to say

05 Allergies and current medicines

Allergies and reactions (write NONE if none known; include medicine allergies)

Current medicines, doses and supplements (or attach a current list)

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Your health information and registration acknowledgement.

Patient full name

Date of birth

06 Health history

Current / past medical conditions, operations and approximate dates

Relevant family medical history (optional)

Smoking / vaping status (optional)

Alcohol intake (optional)

Anything else you would like your doctor to know / reason for your first visit

07 Privacy and acknowledgement

This form collects your personal and health information to help register you and support your healthcare. Please ask reception for the practice privacy policy and collection notice before completing this section. These explain how information is handled, who it may be shared with, and how to request access, correction or make a privacy complaint.

Privacy information

☐ I have received / had access to the privacy policy and collection notice.

Collection of information for my healthcare

☐ I consent ☐ I would like to discuss this with staff

I confirm the details provided are accurate to the best of my knowledge. I understand that treatment decisions and any consent to treatment will be discussed separately with my clinician.

Patient / parent / guardian signature

Date

Signatory name (if signing for the patient)

Relationship / authority to sign