



# Welcome to Gordon 7 Day Medical Centre

Keeping you and your family in good health is our mission. Please assist us by completing all details on this **New Patient Registration Form** and present it to our staff with your **Medicare Card** and **valid photo ID**.

## Patient Information (Please complete ALL 12 fields & Sign Below)

Title: Mr Mrs Ms Miss Dr

1. Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Address: \_\_\_\_\_ Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

3. Mobile: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

4. Email Address: \_\_\_\_\_

5. Medicare Card? Yes / No

Medicare Card Number: \_\_\_\_\_

Reference Number (In front of Name): \_\_\_\_\_ Expiry Month/Year: \_\_\_\_/\_\_\_\_

6. Concession Card? Please circle: None Health Care Card Pensioner Card

Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

7. DVA Card Number? Yes / No Number: \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

8. Emergency Contact Person Name: \_\_\_\_\_

Relationship To You: \_\_\_\_\_

Phone Number: \_\_\_\_\_

9. Ethnicity Please circle: Australian English Chinese Indian Other: \_\_\_\_\_

To help with health initiatives, are you of **Aboriginal or Torres Strait Islander Heritage**? Yes / No

10. Occupation: \_\_\_\_\_ / Not Employed

11. Allergies Do you have any allergies or sensitivity to drugs or dressings? None

Please list: \_\_\_\_\_

12. Feedback How did you find out about Gordon 7 Day Medical Centre? Please circle:

Referral by Family/Friend | Walking by | Flyer | Online/Google | Magnets | Chemist | Other: \_\_\_\_\_

## Patient Consent

- I agree that if I do not attend my GP appointment or fail to give 2 hour notice to cancel my appointment, I will be required to pay a \$20 Non-Attendance Fee. I am also aware that if I run more than 20 minutes late to my appointment that I will need to reschedule for another appointment.
- I give permission for my medical records and personal health information to be shared between the doctors of this practice and any affiliated practices of this group for the purposes of my medical care.
- I authorise Gordon 7 Day Medical Centre to access and upload my shared health summary to My Health Record.
- I agree to allow my doctor to communicate relevant medical information to specialists, hospital staff, pathology labs, and other health care providers involved in my medical care. I also understand that should I not want my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor.
- I consent to be contacted by SMS for medical notifications.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please turn over the page to complete your Health Summary**

(Office Use Only)

All Mandatory Fields Completed: \_\_\_\_/12

Staff Name: \_\_\_\_\_

# Medical Health Summary

Please list all **CURRENT MEDICATIONS** you take: None

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Please list any **CURRENT MEDICAL CONDITIONS** you have if any: None  
eg: asthma, eczema, high blood pressure, high cholesterol

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Please list any significant **PAST MEDICAL CONDITIONS** or reasons for hospitalisation if any: None  
eg: appendectomy, fracture, surgery

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Do you have a **Family History** of the following conditions? Please tick

	Diabetes	Hypertension	Ischaemic Heart Disease	Stroke	Depression	Asthma	Cancer (specify type)	Other Condition
Mother								
Father								
Brother								
Sister								

**Do you smoke?** No / Yes      If Yes, how many cigarettes do you smoke per day? \_\_\_\_\_

**How much alcohol do you consume?** Number of days per week \_\_\_\_\_ Number of drinks per session \_\_\_\_\_

<p><b>Women's Health (18-70 years old)</b> When was your last pap smear?</p> <p>Date: ___/___/___ or</p> <p><input type="checkbox"/> Within 2 years <input type="checkbox"/> More than 2 years ago <input type="checkbox"/> Never <input type="checkbox"/> Not required</p> <p>Were the results:</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>	<p><b>Women &amp; Men</b> When was your last blood sugar/cholesterol test?</p> <p>Date: ___/___/___ or</p> <p><input type="checkbox"/> Within 1 year <input type="checkbox"/> More than 1 year ago <input type="checkbox"/> Never</p> <p>Were the results:</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>	<p><b>Men's Health (over 50 years old)</b> When was your last prostate/PSA test?</p> <p>Date: ___/___/___ or</p> <p><input type="checkbox"/> Within 1 year <input type="checkbox"/> More than 1 year ago <input type="checkbox"/> Never</p> <p>Were the results:</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>
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Thank you for completing this form.



Book your next appointment **ONLINE!**

Through our website [www.Gordon7DayMedicalCentre.com.au](http://www.Gordon7DayMedicalCentre.com.au) or download the free app 'APPOINTUIT'

