BOOROWA HOSPITAL MEDICAL CENTRE

Address: 20 Jugiong Street Boorowa NSW 2586
Phone: 02-63853482 Fax: 02-63851433

Patient Registration Form – Confidential Information

Contact Information

Today's Date:	Date of Birth:	Occupation:
Surname:	First Name:	Middle Name:
Gender:	Title: Mr./ Mrs./ Ms./Miss /Master/ Others	Married/Single/Other
Address:		
Home Phone:	Mobile Phone:	Email:

Emergency Contact Details

Name:	Relationship to you:	Contact number:

Next of Kin

Name:	Relationship to you:	Contact number:

Healthcare Identifiers

Medicare Number:	Ref:	Expiry: ___/_____
Dept. of Veterans' Affairs File Number:		Expiry: ___/_____
Concession (Pension/Health Care) Card Number:		Expiry: ___/_____
Private Health Insurance:	Card number:	Expiry: ___/_____

Cultural Identity

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

Do you identify as someone from a culturally and/or linguistic diverse background? Ethnicity?

☐ No ☐ Yes, _____ *If yes, do you require an interpreter service?* ☐ No ☐ Yes

Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings? ☐ No ☐ Yes, details:

Allergy:	Reaction:	Severity:

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery: _____ ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Others: _____

LIFESTYLE RISK FACTOR INFORMATION

Smoking	☐ No	☐ Ceased - date_____	☐ Yes - how many ___ day / ___ week
Alcohol	☐ No	☐ Yes - how many ___ day / ___ week / ___ month	
Recreational Drug Use	☐ No	☐ Yes - type_____ frequency _____	

Family Health History Information

Have any members of your family have:

☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Mental Illness ☐ Hypertension (high blood pressure)

☐ Cancer – type: _____ ☐ Other significant: _____

Other

How did you know about us? ☐ Word of mouth ☐ Google ☐ Other: _____

Consent

Would you consent for us to inform securely to My Health Record, a Third Party (eg. Specialists/Hospitals)

Recall letters for further Medical Care? ☐ Yes ☐ No

EMERGENCY CONTACT NO.: AMBULANCE / POLICE / FIRE: 000

_____
Patient Signature / If not patient signing, Print Name & Relationship to Patient

PRACTICE USE ONLY:

_____
Witnessed & Checked by Staff