Patient Registration Form

Welcome to Vitalis Healthcare. We are committed to providing our patients with the best care.
To do this it is essential that your health record is kept up to date and accurate.

vitalis HEALTHCARE

YOUR PERSONAL DETAILS

First name:

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:

Middle name:

Preferred name:

Last name:

Date of birth: __ __ / __ __ / __ __ __ __

YOUR RESIDENTIAL ADDRESS

Street:

City/Suburb:

Postcode:

YOUR POSTAL ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADRESS)

Street:

City/Suburb:

Postcode:

YOUR PHONE NUMBER(S) AND EMAIL ADDRESS

Home: __ __ __ __ __ __ __ __ __ __

Work: __ __ __ __ __ __ __ __ __ __

Mobile: __ __ __ __ __ __ __ __ __ __

Email address:

Preferred contact option: ☐ Home phone ☐ Work phone ☐ Mobile phone ☐ SMS ☐ Email

Do you consent to receive appointment reminders by SMS? ☐ Yes ☐ No

REFERRAL SOURCE

How did you hear about our practice?

YOUR RELATION TO HEALTH INITIATIVES - DO YOU IDENTIFY YOURSELF AS ABORIGINAL OR TORRES STRAIT ISLANDER?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

If no, what is your ethnicity?

YOUR MEDICARE INFORMATION

Medicare No.: __ __ __ __ __ __ __ __ __ __ __

Line No.: __

Expiry: __ __ / __ __ __ __

YOUR PENSION INFORMATION (IF APPLICABLE)

Pension/HCC No.:

Ref. No.:

Expiry: __ __ / __ __ / __ __ __ __

Card type: ☐ Pension Concession Card ☐ Healthcare Card ☐ Commonwealth Senior Health Card

DVA No.: ☐ Gold ☐ White ☐ Lilac ☐ Orange

YOUR HEALTH HISTORY

Do you have allergies or are you sensitive to drugs or dressings? ☐ Yes - Please list below ☐ No

YOUR RELATION TO TOBACCO

☐ I have never smoked

☐ I smoke _____ per day / week

☐ I ceased smoking: __ __ / __ __ / __ __ __ __

YOUR RELATION TO ALCOHOL

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many days per week? _____

How many standard drinks per day? _____

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YOUR NEXT OF KIN

Name:	Relation:	Phone:

YOUR EMERGENCY CONTACT (PLEASE FILL OUT, OTHERWISE WE CONSIDER YOUR NEXT OF KIN YOUR EMERGENCY CONTACT)

Name:	Relation:	Phone:

DO YOU INTEND TO HAVE ONGOING MEDICAL CARE PROVIDED BY VITALIS FAMILY MEDICAL PRACTICE?

☐ Yes ☐ No

This practice collects information from you for the primary purpose of providing comprehensive quality medical care. It is important that you do not withold information that would influence the medical treatment or advice given. We are committed to patient privacy and confidentiality and will only release information about you to other health professionals involved in your care or when the law requires us to do so. Please do not hesitate to discuss any concerns or questions about any issues to the privacy of your personal information with your Doctor.

From time to time we may wish to contact you to inform you of new services offered by the practice, updates to the practice policies or procedures or for occasional practice newsletters.

If you DO NOT wish to receive this type of communication please tick the box. ☐

YOUR SIGNATURE	DATE

THIS SECTION SHOULD ONLY BE FILLED IF PATIENT IS UNDER 18 YEARS

HEAD OF FAMILY

Are you an existing patient: ☐ Yes, Name: ☐ No (if no, please complete below)

HEAD OF FAMILY PERSONAL DETAILS

First name:	Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:
Middle name:	Preferred name:
Last name:	Date of birth: __ __ / __ __ / __ __ __ __

HEAD OF FAMILY RESIDENTIAL ADDRESS (IF DIFFERENT FROM PATIENT)

Street:	City/Suburb:	Postcode:

HEAD OF FAMILY PHONE NUMBER(S) AND EMAIL ADDRESS (IF DIFFERENT FROM PATIENT)

Home: __ __ __ __ __ __ __ __ __ __	Work: __ __ __ __ __ __ __ __ __ __
Mobile: __ __ __ __ __ __ __ __ __ __	Email address:

HEAD OF FAMILY MEDICARE INFORMATION

Medicare No.: __ __ __ __ __ __ __ __ __ __	Line No.: __	Expiry: __ __ / __ __ __ __

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