BETTER MEDICINE HEALTH CENTRE & SKIN CLINIC

Phone: (02) 9880 7688 Fax: (02) 9880 7699

PATIENT DEMOGRAPHIC REGISTRATION FORM

Title: □ Mr □ Mrs □ Ms □ Miss □ Other_______	First Name: Surname:
Birth Sex: □ Male □ Female □ Other:_________	Date of Birth (DD/MM/YYYY):
Marital Status: □Single □Married □Defacto □Separated □Divorced □Widowed	Ethnicity: □Australian □Chinese □Other: ___________
Gender Identify: □ Male □ Female □ Gender diverse □ Transgender □ Other:__________________	
Are you of Aboriginal or Torres Strait Islander origin? □ No □ Yes Aboriginal □Yes Torres Strait Islander □Both Aboriginal and Torres Strait Islander	
Medicare Card:	# Ref: Expiry:
Private Health Fund:	# Ref:
Do you have a Centrelink / Pensioner Concession / Seniors Healthcare Card?	□ No □ Yes # Expiry:
Unit/Street Number/Street Address	
Suburb	Postcode
Mobile Phone No.	
Email Address(please write in CAPITAL LETTERS)	
Next of Kin	First Name / Last name / Relationship to you / Contact No.
Emergency Contact □ Same as Next of Kin	First Name / Last name / Relationship to you / Contact No.

ALLERGY: Do you have allergies to any medication?
□ Nil known □ Yes. Please specify: ______________

MY HEALTH RECORD (MEDICARE CARD HOLDERS ONLY)

MyHealthRecord allows allergies, significant conditions, medications and immunisation records accessible online by you and other Healthcare Providers.
All **IMMUNISATION RECORDS** at this clinic will be uploaded to MyHealthRecord.
Please tick 'YES' if you DO wish to have your ALLERGY, MEDICAL HISTORY, MEDICATION and IMMUNISATION RECORDS updated on MyHealthRecord □**YES**

RECALLS & REMINDER SYSTEM

Our practice has a recall system in place for results that need to be followed up with an appointment. All results are discussed by the Doctor only.
We also provide our patients with routine preventive care reminders e.g. follow up immunisations, annual skin checks and cervical screenings etc.
Please tick 'No' if you DO NOT wish to have **PREVENTATIVE CARE REMINDERS** sent to you □**No**

Significant Past/Active Medical Conditions:

Family History - Any significant family history of illness & cancer?
□ No □ Yes (please specify on condition and relationship to you)

Occupation:	**Alcohol:** □ No □ Yes: ____ days per week ____ standard drinks per day	**Tobacco:** □ No □ Ceased smoking □ Yes: cigarettes ____ per day

For each consultation either by telehealth, telephone or in person, including but not limited to health assessments and management plans, I offer to assign my rights to Medicare benefits to the doctors of Better Medicine health centre & skin clinic who will render the medical service(s). I understand it is necessary for this Practice to collect personal information from me for the purpose of health management and for associated administrative purposes. I consent to the Practice's Electronic Communication Policy and Privacy Policy on handling patient information. Both can be made available to me on request. I understand that failure to provide this Practice with all the information it needs may restrict its ability to provide the quality of health care that I want. I acknowledge that I have read and understood this form before signing.

□ **I aware that Better Medicine is a PRIVATE BILLING GP Practice, I will settle the payment after every visit.**

Signature:____ Date: ____/____/________