PYMBLE
Medical & Dental
CENTRE

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Pymble NSW 2073
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FAMILY MEDICAL REGISTRATION FORM

<u>**16yrs and over must complete & sign their own form**</u>

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. Adult/parent to complete the top half of the form.

ADULT / PARENT DETAILS

Title	Mr	Mrs	Ms	Miss	Dr
Surname		**Date of Birth**			
Given Name		Preferred Name			
Street Address					
Suburb & Postcode					
Home Phone		Work Phone		Mobile Phone	
Email				Tick to opt out of SMS appointment reminders	
Medicare Number		Position on card		Expiry Date	

CHILDREN UNDER 16 DETAILS BELOW

Name	**Surname**	**Date of birth**	**M/F**	**MC Position**

DVA Gold / White /Orange (pls circle)		Expiry Date	
Pension Number		Expiry Date	
Comm. Snrs Health Care Card #			
Health Care Card #		Expiry Date	
Private Health Fund			
Next of Kin	**(Name, relationship and telephone number of the person we can contact if needed)**		
Emergency Contact	**(Name, relationship and telephone number of the person we can contact if needed)**		

PLEASE TURN OVER FOR SIGNATURE & MEDICAL HISTORY →

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.
Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes – Please elaborate _____
☐ Do you need a translator?

To assist with health initiatives please tell us about your background.
☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander Heritage _____

Significant Family Medical History:

_____

Significant Medical & Surgical History: (please notate patient)

_____

_____

Any allergies or sensitive to drugs or dressings? (please notate patient)

☐ Yes(pls specify)_____ ☐ No

Current medications (including over the counter medications, vitamins and minerals)/or other health supplements. (please notate patient)

_____

_____

If we need to contact you what is your preferred method of contact:
☐ Home phone ☐ Work phone ☐ Mobile phone

How did you hear about us?
☐ Website ☐ Walk/Drive By ☐ Letterbox Flyer ☐ Family/Friends ☐ Other _____

Cancellation of appointment:
Please be advised appointments should be cancelled 2hrs prior to appointment time or a cancellation fee of $50.00 will be issued.

Your Privacy & Medical Information

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside the practice and disclosure to other doctors in the practice including locums to assist in your medical care. The practice may occasionally be involved in research and quality assurance activities to improve individual and community health and practice management. We wish to assure you that at all times your health information is treated with utmost confidentiality.
I have read and understood the above information regarding my medical information and am aware I can request a full copy of the privacy and collection statement.

_____/____/____
Signature of patient/Head (or guardian if *under 16*) Date
PLEASE PROVIDE PHOTO ID TO ACCOMPANY THIS REGISTRATION FORM IF YOU ARE OVER 18.