PATIENT REGISTRATION FORM

MAIN ROAD MEDICAL

Title ____ Family Name ____ Given Name ____

Date of Birth ____ Aboriginal ☐ Torres Strait Islander ☐

Address ____

Phone 1 ____ Phone 2 ____

Email ____ Occupation ____

Emergency Contact 1. Name ____ Phone ____ Relationship ____

Emergency Contact 2. Name ____ Phone ____ Relationship ____

Medicare Number ____ Ref Number ____ Expiry ____

Pension / Health Care Card ____ Expiry ____

DVA Card ____ Expiry ____

Current Medications ____

Allergy ____

Chronic or recurrent illness ____

Operations ____

Alcohol Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-4 times a week ☐ 4+ times a week ☐

How many Standard Drinks on a typical day? ____

Tobacco Never ☐ Ceased from year ____ Currently smoking ____ cigarettes per day

Vigorous exercise (running, swimming, aerobics, zoomba, tennis, bicycle riding, ...)

How many days a week? ____ How many minutes on each day? ____

If you are 50 or older Have you had Bowel Cancer Screening Test? ☐ when ____

If you are female Have you had Cervical Screening (PAP) Test? ☐ when ____

Have you had Mammogram? ☐ when ____

Family history: Please list family members with

Diabetes ____ Heart Disease ____

Strokes ____ Cancer ____

I have read about Health Information Collection & Use on MRmedical.com.au
and consent to the handling of my information by the practice ☐

Signature of Patient or Guardian .... Date ____