TOPDOCTORS
MEDICAL SKIN COSMETICS

NEW PATIENT REGISTRATION FORM

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐	
Last Name:	**Given names:**
Date of Birth:	Gender: Male ☐ Female ☐ Other ☐
Street address: Suburb: Postcode:	Home: Mobile: Email:

MEDICARE CARD NUMBER: _____

Reference number (number on left side of your name):_____ Expiry Date:_____

Do you have any Concession Cards? ☐Health Care Card ☐Pension Card ☐Commonwealth Seniors Card	Entitlement number: Expiry Date:
DVA Card? ☐White ☐Gold	Entitlement number: Expiry Date:

	Name:	Relationship:	Phone Number:
Next of Kin			
Emergency Contact			

Patient Occupation:

Marital Status: ☐Defacto ☐Married ☐Divorced ☐Widowed ☐Other

The following information will assist us in the planning and provision of the best possible care.	Ethnicity and/or Country of Birth:
Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander	Is English your first language: ☐ Yes ☐ No If English is not your first language, do you require an interpreter? ☐ Yes ☐ No

How would you like us to contact you? ☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Post

We will routinely use SMS, mail or phone for appointment reminders, recalls and preventative care reminders as our method of contact. Please advise (tick box) if you do not wish to be contacted via these methods ☐

Privacy statement:

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

☐ **I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE**

Signature: **Date:**

Address: 3/2 Eucalypt Street, Bellara, QLD 4507
Tel: (07) 37784371 www.Topdoctors.au reception@topdoctors.au

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PATIENT NAME: _____ DOB: _____

Your Medical History
Height: _____ **Weight:**_____

Do you suffer from any medical problems? ☐ YES☐ NO
If yes, please list them below with year of diagnosis:
_____
_____

Have you had any operations/surgery? ☐ YES ☐ NO
If yes, please list them below with year of procedure:
_____
_____

Are you suffering from any mental health disorders? Are you on any medication for mental health ?
_____
_____

Please list down any current medications (prescription and non-prescription) that you are taking.
_____
_____

Do you have any allergies? ☐ YES ☐ NO
If yes, please list below (include type of reaction, if known):
_____

Are you a smoker? ☐ YES ☐ NO ☐ EX-SMOKER
If yes, how many do you smoke _____/day.
When did you start smoking _____ (Year commenced)
If you are an ex-smoker, when did you stop? _____ How many were you smoking _____/day.
How many days a week do you consume alcohol? _____ days/week
How much alcohol would you consume on each occasion? _____ SD
(Please enter appropriate number of standard drinks. 1 standard drink = 1 glass of wine OR 1 can/pot of beer OR 30mL of spirits)

Family History (Parents/Grandparents/Siblings)
Do any of your family members suffer from:
Cancer ☐ YES ☐ NO
High Blood Pressure ☐ YES ☐ NO
Heart Disease ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO
Any Genetic disorders ☐ YES☐ NO

Signature: _____ Date: _____

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