STIRK MEDICAL GROUP

PATIENT REGISTRATION FORM

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. **ALL SECTIONS MUST BE COMPLETED.**

Title:	☐ Mr ☐ Mrs ☐ Ms ☐ Master ☐ Miss ☐ Dr ☐ Other:_____		
Surname:		**First Name:**	
Middle Name:		**Preferred Name:**	
Gender:	☐ Male ☐ Female ☐ Other	**Date of Birth** / /	
Ethnic Background: ***(or country of birth)***		**Occupation:**	
Aboriginal or Torres Strait Islander	☐Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ No		
Street Address:			**Suburb:**
Postcode:		**Postal Address:** *(if different from above)*	
Contact Number:	Home:	Work:	Mobile:
Email Address:			
Medicare Card Number:	_ _ _ _ _ / _ _ _ _ _ _ / _		**Ref No**. __ (in front of your name) **Expiry:**
Pension/Health Care Card Number: ***(not private health)***	_____ ☐ Pension Card or ☐ Health Care Card		Expiry:
DVA Number :	_____Gold / White *(please circle)*		Expiry:
Emergency Contact or Next of Kin:	First Name: Last Name: Contact Number: Relationship:		

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HEALTH SUMMARY/HISTORY

Do you have/had in the past any of the following?	☐ Diabetes ☐ Asthma ☐ Hypertension ☐ Chronic Illness ☐ Operations ☐ Other (Please state): _____ _____
Family history:	☐ Diabetes ☐ Asthma ☐ Cancer ☐ Mental Illness ☐ Heart disease ☐ Other (Please state): _____ _____
Do you have any ALLERGIES? ☐ Yes (Please specify) _____ ☐ No **What type of reaction do you have?** _____ **Are you sensitive to any drugs or dressings?** ☐ Yes (Please specify) _____ ☐ No	
Immunisations – Have you had the following?	Influenza ____/____/____ Unsure No Tetanus booster ____/____/____ Unsure No Pneumococcal ____/____/____ Unsure No Polio ____/____/____ Unsure No
If completing form for a child, are immunisations up to date?	Yes / No
Over 65s:	**When was the last time you were immunised?** Influenza ____/____/____ Unsure Haven't Had Pneumococcal pneumonia ____/____/____ Unsure Haven't Had
Current medications:	**Please list:** _____ _____ _____ _____ _____ _____
Social history:	Tobacco: How many ___ per day / week or ceased smoking (please circle) Alcohol: How many ___ per day / week / month (please circle)

Reminder System Our practice provides our patients with preventative and early detection reminders e.g Immunisations, annual health checks, skin checks and pap smears.

ALL ACCOUNTS ARE THE RESPONSIBILTY OF THE PATIENT. Once payment has been made in full, we will send your account to Medicare for your refund to go to your nominated account. I am aware there may be a gap.

Patient signature: _____ Date: _____

How did you hear about us? ☐ Flyer ☐ Signage ☐ Recommended ☐ Online /Website ☐ Live in area ☐ Other: _____