Office use only

Scanned By :

Date:

ROCKINGHAM GP
Western Healthcare

Patient Registration Form

Unit 11, 7-9 Goddard Street
Rockingham WA 6168
P: 08 9528 5000, F: 08 9592 6779
Email info@rockinghamgp.com.au
Web: www.rockinghamgp.com.au
ABN 12364976224

Surname:	Given Names:	Gender □M □F	Date of Birth:

Street Address:	Suburb	Postcode:	State:

Home Phone:	Mobile:	Work Phone:
	Consent to SMS reminders □Yes □ No	

Email:

Occupation:
Employer:

Are you an Aboriginal or Torres Strait Islander? Yes ☐ No☐
Your Ethnicity _____

Medicare No : | | | | | | | | | | |

Ref No : | |

Valid To: | | | / | | |

Do you have Veteran Affairs File No? If yes Provide | | | | | | | Type: □Gold □Orange □White

Do you have any other Australian Government Concession Card? Please provide details
Type: Number : Valid to:

Do have any Private Health Insurance? Please provide details
Name of the Insurer: Member No:

Emergency Contact:
Name: Relationship: Contact No:

Do you smoke? □Yes □No If yes ___ Cigarettes per day

Alcohol Consumption: _____ Glasses per week

ALLERGIES
If no Allergies Please tick □

Substance Reaction

CURRENT MEDICATION
If no medication please tick □

Medication Dose Frequency

FAMILY HISTORY
Any history of Cancers, Diabetes, Heart diseases etc.

Relationship Condition

In accordance with the *Privacy Act (1988)*, all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.

Selected information may be disclosed to various other health services involved in supporting your health care management, (e.g. Pathology & Radiology)

Please Note – Due to privacy laws it is preferred that adults and over sixteens arrange their own appointments whenever possible. Results **cannot** be given to a third party except under special circumstances.

CONSENT

☐ I consent to the use of my personal health information by Haynes Rockingham GP and other health providers involved in my medical treatment and health care.

☐ I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Signature: - …… **Date: - …….. /…….. /……..**

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