

PANACEA HEALTH CLINIC

13A Buller St, North Parramatta NSW 2151
www.panaceahealthclinic.com

Phone: (02) 9890 7755
Fax: (02) 9613 3999



New patient registration form

Please print letters

Use black or blue pen

Place in all applicable boxes

We need this information to provide the best quality health care. Your personal information is kept private and secure, as required by federal and state privacy laws. If you have any concerns please leave blank and discuss with your GP or nurse. Please notify us promptly of any changes in your contact details. Having accurate contact details helps us to identify you and your medical records and allows us to contact you about tests and results.

Section A: Personal details

Title Surname Given names

Date of birth / / Gender Male Female Marital status Single Married De facto Separated Divorced Widowed

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Ethnicity Country of birth

Is English your first language? Yes No If not do you require an interpreter? Yes No Please specify language

Home address Suburb Postcode

Postal address Suburb Postcode

Telephone Number Work number Mobile number

Email

Medicare Card Number Card reference number Expiry date /

Pension, Health Care Card or Veterans Affairs number (if applicable) Type of Card Expiry date / /

Health Insurance Fund Health Insurance No. Expiry date / /

Occupation
Religion

Next of Kin?

Name	Relationship to you
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Telephone Number	Work number	Mobile number
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Who can we contact in an emergency?

Name	Relationship to you
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Telephone Number	Work number	Mobile number
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Section B: Allergies

List allergies and intolerances to medication

Describe your reaction i.e rash, nausea

Mild/Moderate/Severe
Mild/Moderate/Severe
Mild/Moderate/Severe

Medication - List regular medications and dosages and complementary medications and dosages

Section C: Consent

Our practice uses a reminder system to help you maintain your health. This practice sends out reminders by post, email, telephone and SMS for procedures such as pap smears, health reviews and vaccinations.

I consent to an SMS being sent to my mobile to confirm my appointments.

Yes No

I consent to being contacted for reminders to help maintain my health.

Yes No

Signature of patient or guardian

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Date

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Section E: Transfer of health information

You may have consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or summary of your health records transferred to this practice. Please ask the receptionist for information on how this can take place.

Please advise us if your contact information or Medicare details change.

Office use only; Entered by _____

Medicare online verification done (please circle) yes/no

HIP-I number entered (please circle) yes/no