Lifetime Health
MEDICAL CENTRE

ABN: 25 569 812 490
Shop 204 / 67 Regatta Blvd, Birtinya Qld 4575
Phone: 07 5437 6324
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NEW PATIENT REGISTRATION FORM

Title: _____ **Family Name:** _____

Given Name: _____ **Middle Name:** _____

Preferred Name: _____ **Date of Birth:**_____

Birth Sex: **Female** **Male**

Gender Identity: **Female** **Male** **Non-Binary** **Gender diverse** **Transgender** **Different identity** _____

Ethnicity: **Aboriginal** **Torres Strait Islander** **Australian/Non-Indigenous** **Other**:_____

Are you registered for the CTG PBS co-payment? **Yes** **No**

Occupation:_____

CONTACT DETAILS:

Residential Address: _____

_____

Postal Address: _____

Home Phone :_____ Work Phone:_____

Mobile: _____Email:_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ **Reference Number:** __ (left of your name) **Exp:** ____/____

Pension Card / Healthcare Card _____**Expiry date:** _____/_____/_____

DVA : _____ **TYPE:** _____

NEXT OF KIN

Full Name:_____ **Contact Number:** _____ **Relationship to you:**_____

EMERGENCY CONTACT

Full Name:_____ **Contact Number:** _____ **Relationship to you:**_____

CONSENT:

By becoming a patient of Lifetime Health Medical Centre and signing below, I agree and consent to:
* Disclosure of selected personal health information to others involved in my treatment and care, such as: a treating hospital, specialist, pathology and imaging providers. The practice will only disclose those details necessary for me to receive appropriate care from the health service concerned. Limited information must be disclosed by law to Government bodies for billing services e.g.: Medicare.
* Contact by the practice via mail, phone, email or SMS for Recalls and Reminders.
* the Practice's Billing Policy.

Patient / Guardian Name: _____ **Date:** ____/_____/____

Signature: _____

Please complete this form fully, as it will assist us with the management and continuity of your health care.

PATIENT HISTORY:

OPERATIONS / ILLNESSES: _____

_____

ALLERGIES: _____

_____

MEDICATIONS: (List all medications you are taking NOW) _____

_____

_____

SIGNIFICANT FAMILY HISTORY: (Please Circle)

Nil Known **No Significant history**

MOTHER: (Please Circle) **Diabetes** **Colon Cancer** **Hypertension** **Depression**

Heart Disease **Breast Cancer** **Stroke**

FATHER : (Please Circle) **Diabetes** **Colon Cancer** **Hypertension** **Depression**

Heart Disease **Stroke**

MARITAL STATUS: (Please Circle) **Married** **Single** **de facto** **Separated** **Divorced** **Widowed**

ACCOMMODATION: (Please Circle) **Own Home / Renting / Nursing Home / Hostel / Homeless / Relative**

Who do you live with? _____

Do you have a Carer? _____

ALCOHOL: (Please Circle) **Non Drinker** **Drinker**

Days per week: _____ **Standard drinks per day:** _____

SMOKING: (Please Circle) **Smoker** **Non Smoker** **Ex-Smoker** **Date ceased:** _____

How many per Day? _____

ARE YOU... (Please Circle) **On holiday** **Visiting relatives** **Relocated to the Sunshine Coast**

How did you hear about Lifetime Health Medical Centre?

_____

_____