

# New Patient Registration Form

We need this information to provide the best quality care. This form complies with the RACGP Standards for general practice. This means your personal health information is kept private and secure as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. Please notify us promptly of any change in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

## Section A: Personal Details

Title	Surname	Given Names	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>
Medicare Card No.	Ref No.	Occupation/School	Contact Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal Address	Suburb	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Pension or Veterans Affairs Card no. (if applicable)	Type	Expiry Date	
<input type="text"/>	<input type="text"/>	<input type="text" value="/"/> <input type="text" value="/"/> <input type="text"/>	
Email			
<input type="text"/>			
Next of Kin	Contact Number	Relationship	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Emergency Contact	Contact Number	Relationship	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

## Section B: Skin History & Consent

When was your last skin check?	Do you have any history of skin cancer?
<input type="text"/>	<input type="text"/>
What Country and state did you spend the first 25 years of your life?	Do you have a family history of Melanoma?
<input type="text"/>	<input type="text"/>
Have you used Tanning Beds?	Do you have any severe sun damage history? (i.e. blisterings)
<input type="text"/>	<input type="text"/>
Are you immunosuppressed?	Are you on blood thinners?
<input type="text"/>	<input type="text"/>
I consent to a full skin examination down to underwear?	Do you require a chaperone?
<input type="text"/>	<input type="text"/>

## Section C: Consent

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

<b>Are you of Aboriginal or Torres Strait Islander origin?</b> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> <b>Other Cultural Background</b> (eg. African, Asian, European) <input type="text"/>	<b>Country of Birth</b> <input type="text"/> <b>If you require an interpreter, please specify language</b> <input type="text"/>
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Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone, or SMS for procedures such as vaccinations, Skin checks and other health reviews. Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders which can be helpful if you move.

I consent to being contacted with reminders to help me maintain my health and receive guidance for result follow up via text message. My GP will discuss this plan during the appointment, when arranging specific investigations. If I have not received a text message 2 weeks after the investigation, I will call the clinic. Yes  No

## Section D: Additional Information (Optional)

### How did you initially learn about The Skin Cancer Clinic Claremont? (Please Circle)

Newspaper      Instagram      Health professional      Facebook      Other: \_\_\_\_\_  
Identified from street      Friend/relative      Adjacent pharmacy      Google Search

### Did you have any problems locating The Skin Cancer Clinic Claremont when you attended your appointment?

Yes       No

### Why did you choose The Skin Cancer Clinic Claremont for this appointment? (Please Circle)

Location      Facilities      Previously saw doctor at another clinic      Onsite pathology      Other: \_\_\_\_\_  
Individual doctor skill set      Opening hours      Adjacent pharmacy

**Signature of patient or guardian**

**Date**

/ /

### RECEPTION STAFF TO COMPLETE:

IS THIS PATIENT A MINOR?

YES       NO

IF YES, ARE THE PARENT/ LEGAL GUARDIAN DETAILS RECORDED (*Next of Kin*)?

YES       N/A

ARE ALL THE DETAILS ENTERED ON PRACSOFT?

YES       NO

REMOVED 'DO NOT SEND SMS' IF CONSENTED

YES       NO

INITIAL: \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_