KENOLTA MEDICAL CENTRE	T 02 5104 3966 F 02 5104 3818 E reception@kenolta.com.au 9/34-38 O'Hanlon Place, Nicholls, ACT 2913 www.kenolta.com.au
	Personalised, holistic care with excellence

New Patient Registration Form – (*this is a 3 page document*)

This form contains important information required to:

- Register you as a patient at KENOLTA Medical Centre
- Enable us contact you when required
- Provide us a baseline on your past and current medical history
- Enable us provide you with quality Healthcare

- **To ensure we have your correct details:**
- **Please provide all relevant information clearly and legibly.**
- **Write in Capital letters where possible.**

- **It is important that you promptly notify us of any changes to your contact details.**
- **Accurate and up to date details help us identify you, your medical records and enable us to contact you if / or when required e.g notification about apppointments, tests and results.**

- **Sign Page 3.**

- **Information provided on this form is treated with confidentiality and in compliance with privacy laws.**

Title:	Mr Mrs Ms Miss Mast Other:_____	Medicare Card Details	Number:
Surname:			Line No on Card Exp:
Given Name(s):		DVA No:	Number:
Preferred Name:		Pension / Healthcare Card	Number:
Date of Birth:		Card Type:	Exp Date:
Birth Sex	Male Female Other Unknown	Health Insurance Fund Name:	
Gender:	Male Female Other	Fund Number:	

Are you of Aboriginal or Torres Strait Islander Origin?
☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Ethnicity:
What is your marital status? ☐ Single ☐ Married ☐ Defacto ☐ Divorced ☐ Widowed

Home Address:			
Postal Address:			
Phone:	(M)	(H)	(W)
Email Address:			
Occupation:			

Name of Emergency Contact Person:			
Emergency Contact's phone number:		Relationship:	
Do you have any allergies? Yes / No. - If Yes, list all known allergies			
Do you have any personal or family history of:	Self or family member (e.g mother,father,etc.)		
Diabetes Y / N		Is your mother alive? (OPTIONAL)	☐ Yes ☐ No Age at death:
Hypertension Y / N		Cause of death:	
Heart Disease Y / N		Is your father alive? (OPTIONAL)	☐ Yes ☐ No Age at death:
Stroke Y / N		Cause of death:	
Bowel Cancer Y / N			
Breast Cancer Y / N			
Depression Y / N		Are you an elite athlete?	☐ Yes ☐ No
Others (please list)			
Do you have a carer? Y / N	If yes, please provide carer details		

Do you engage in any recreational activities e.g. walking, jogging etc? If yes, please provide details and how often			
Do you currently drink alcohol?	Y es / No	How many per day? 1 2-3 4-6 7+	How many days do you drink per week? 1 2 3 4 5 6 7
Past alcohol intake:	Nil Occasional Moderate Heavy	Year started:	Year ceased:
Do you currently smoke? Yes / No	If yes, approx. how many cigarettes per day?		

Previous smoking history:	Nil Light Moderate Heavy	Year started:	Year ceased:
Do you take any prescription medications? Yes / No	If Yes, please list all medications and dosage below		
Do you take any over the counter medications? Yes / No	If Yes, please list all medications and dosage below		

LATE CANCELLATIONS & 'DID NOT ATTEND' POLICY:

A fee may be charged if you fail to attend a scheduled appointment or do not provide sufficient notice of an appointment cancellation. By signing this registration form, you acknowledge that you understand and will abide by this policy.

- **PLEASE COMPLETE AND SIGN THE SECTION BELOW**

DECLARATION & CONSENT FOR USE OF INFORMATION:

I confirm that information listed above are correct.

I understand these information will be used by doctors and staff of KENOLTA Medical Centre to fulfil their duties in the course of my healthcare planning and management.

I consent to Clinicians and staff of KENOLTA Medical Centre, other treating practitioners and allied health providers exchanging all relevant information for the purpose of managing my health.

I consent to be contacted with information relevant to my healthcare (including recalls and reminders) using the contact details listed on this form.

Patient/Guardian's Name:_________________________**Signature:**________________**Date:** / /

Individuals aged 18 years and over, must sign their own registration form

AUTHORISED PERSON(S) TO ACT ON YOUR BEHALF (*Optional)

I hereby authorise the following person(s) to act on my behalf in regards to accessing my records, results & other information that may be held by KENOLTA Medical Centre. I understand that I can revoke this authority at any time by contacting KENOLTA Medical Centre in writing.

Contact Person(s) Name(s)____ Relationship to you:______________________________

Their Contact details:(Ph:) ____________________(M) ____________________(Email) __________________________

PREVIOUS MEDICAL RECORDS TRANSFER

The health information held by your previous GP may assist us with your future healthcare needs.

You may wish to have a copy of your previous medical records transferred to this practice.

Please ask the receptionist for information about how we can assist with this.