

Patient Registration Form

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other		
First Name			Preferred Name:
Surname			D.O.B:
Home Address			
Contact numbers	Home:		
	Mobile:	Work:	
Email			
Medicare Number		Reference no:	Expiry:
Private Insurance	Yes <input type="checkbox"/> No <input type="checkbox"/> [This will only be relevant if you're admitted to hospital]		
Next of Kin or Emergency Contact Name			
Next of Kin Phone		Relationship to Patient	
Current Medications	<input type="checkbox"/> Anti-inflammatories: <input type="checkbox"/> Puffers/inhalers: <input type="checkbox"/> Insulin: Please List:		<input type="checkbox"/> Supplements: <input type="checkbox"/> Contraceptive pill/implant: <input type="checkbox"/> ASADA TUE certificate:
Medical Issues	<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disorder <input type="checkbox"/> Eczema/dermatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Migraines <input type="checkbox"/> Bleeding/clotting problems <input type="checkbox"/> Other:		
Allergies			
Smoking Status	<input type="checkbox"/> Smoker: Amount: <input type="checkbox"/> Ex-smoker: <input type="checkbox"/> Nonsmoker:		
Occupation			
Sports/Activities	Please specify:		
Immunisation Status	<input type="checkbox"/> Flu shot this year <input type="checkbox"/> Tetanus shot within 5 years <input type="checkbox"/> Travel immunisations (specify if able):		
Past operations or injuries	<input type="checkbox"/> Hip: Left / Right: Specify: <input type="checkbox"/> Shoulder: Left / Right: Specify: <input type="checkbox"/> Knee: Left / Right: Specify: <input type="checkbox"/> Elbow Left / Right: Specify: <input type="checkbox"/> Ankle: Left / Right: Specify: <input type="checkbox"/> Wrist or hand Left / Right: Specify Other:		
SMS reminders	Our practice will provide a sms reminder service to your mobile for appointments <input type="checkbox"/> Opt Out : If you do not wish to receive reminders this way, please tick this box		

Patient Registration Form

Cancellation Policy

We endeavour to provide prompt access to medical care for acute injuries. Late cancellation of appointments can impact on our ability to achieve this for other patients who miss out on receiving care. **Cancellation with less than 24 hours' notice will result in a cancellation fee being charged that is equal to the Medicare rebate for a standard consultation.** If you need to cancel at short notice due to extenuating circumstances, we may be able to reschedule your appointment and waive any applicable cancellation fee. Please discuss with our helpful staff.

Privacy Policy

This policy provides you, our patient, with information on how your personal information, including your health information, is collected and used within our practice, and the circumstances in which it may be shared with third parties.

When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare. Only staff who need to see your personal information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this.

Our practice also provides an appointment reminder service via sms to your mobile. Please advise by ticking the option to opt out on the bottom of the front page if you do not wish to use this service.

For further information, please refer to our website- www.sportsdocs.com.au

Guardian details for patient under 16

Title (Please tick)	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other				
Surname					
First Name				D.O.B:	
Home Address					
Contact Number					
Medicare Number			Reference no:	Expiry:	