



## NEW PATIENT REGISTRATION FORM

Welcome to The Body Guard clinic. We require this information to provide you with the best quality of care. Our clinic follows the guidelines of best practice for the management of health information in private practice. This means your personal health information is kept private and secure as required by federal and state privacy laws.

Patient Details			
Title	First Name		Surname
Date of Birth	/ /	Age	M / F
Place of Birth		Occupation	
Contact Details			
Home Address			
Suburb		State	Postcode
Ph.(Mobile)		Ph.(Home)	Ph.(W)
E-mail			
Marital Status			
<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> De Facto	<input type="radio"/> Separated
<input type="radio"/> Divorced	<input type="radio"/> Widowed	<input type="radio"/> Other	
No. of Children			
Emergency Contact Details			
Name		Relationship To You	
Ph.(Mobile)		Ph.(Home)	Ph.(W)
Vital Statistics (if known)			
Weight:	Height:	B.P.	Blood Type
Contact Lenses: Yes/No			
Immunisations (please tick relevant boxes)			
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Influenza	
<input type="checkbox"/> Tetanus		<input type="checkbox"/> Childhood vaccines up to date	
<input type="checkbox"/> Other (please specify)			

## New Patient Registration Form – Page 2

<b>Patient Health History</b>	
Please list your current and regular medications including vitamins and herbal medicines	
Have you had any specialist consultations in the last 12 months? If yes, please specify	
Please advise of any pathology tests performed in the last 12 months (where possible provide copies of the test results)	
Please list any allergies and intolerances to medications	
Please list any medical history and past surgery/operations and previous illnesses/injuries	
<b>Women's Health</b>	
Last Pap Smear        /        /	Last Mammogram        /        /
<b>Men's Health</b>	
Last prostate check (if aged over 40)        /        /	
<b>Smoking History</b>	<b>Alcohol</b>
<input type="checkbox"/> Never	<input type="checkbox"/> Non Drinker
<input type="checkbox"/> Former smoker – quit        /        /	<input type="checkbox"/> Rarely/Light
<input type="checkbox"/> Current smoker -        /day	<input type="checkbox"/> Moderate
<input type="checkbox"/> Number of years smoking	<input type="checkbox"/> Heavy
List type of alcohol drunk	
Please list any other recreational drug use. Please note your answers will remain confidential	

## New Patient Registration Form – Page 3

Please indicate whether you have any of the following conditions		
<input type="checkbox"/> High/Low BP	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Fluid Retention
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Fainting/Blackouts	<input type="checkbox"/> Problems with any organs
<input type="checkbox"/> Asthma/chest conditions	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Reproductive problems
<input type="checkbox"/> Respiratory illness	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Sciatica/lumbago/backpain	(how many weeks)
<input type="checkbox"/> Thrombosis/circulatory condition	<input type="checkbox"/> Cancer What type ?	<input type="checkbox"/> Can't get pregnant
<input type="checkbox"/> Haemophilia/bruising	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Stroke	<input type="checkbox"/> Joint pain/discomfort	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stress	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Allergies	<input type="checkbox"/> HIV Positive/Aids	
Do you have any other diseases or conditions that you are aware of? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, please list:		
<b>Family Health History</b>		
Please tick if you or any of your family members have had any of the following.		
Please specify which family member (eg, mother, father, sibling, grandparent, other)		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Heart disease		
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Cancer (please also specify type of cancer)		
<input type="checkbox"/> Obesity		
<input type="checkbox"/> Parkinsons		
<input type="checkbox"/> Alzheimers		
<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> High Blood Pressure		
<b>Insurance and Financials</b>		
Do you have private health cover? Yes/No		Name of Insurer
Are you: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait island <input type="checkbox"/> Non-Indigenous		
Do you have a DVA Gold or White Card ? (If so, please choose one and specify details)		
DVA Gold Card #		DVA White Card#
What is your payment preference?		
<input type="checkbox"/> Cash	<input type="checkbox"/> Direct Deposit	<input type="checkbox"/> Credit Card

## New Patient Registration Form – Page 4

<b>Health Support Team</b>		
Doctor's name		
Doctor's phone no.		
Doctor's email address		
<b>Other Health Care Professionals Currently Consulting (eg, counsellor, specialist, chiro etc)</b>		
<b>Name</b>	<b>Field</b>	<b>Contact</b>
<b>Feedback</b>		
<b>How did you find out about The Body Guard (please tick )</b>		
<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> White Pages	<input type="checkbox"/> Press
<input type="checkbox"/> Relatives	<input type="checkbox"/> Signage	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Workshops	<input type="checkbox"/> Leaflets/flyer	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> School newsletter	<input type="checkbox"/> Notice board	<input type="checkbox"/> Search Engine
<input type="checkbox"/> ANTA website	<input type="checkbox"/> ATMS website	<input type="checkbox"/> Business Breakfast
<input type="checkbox"/> Search Engine	<input type="checkbox"/> Link from other website	<input type="checkbox"/> Email
<input type="checkbox"/> Other (please specify)		

Would you like to receive our newsletter by email? Yes/No

### Privacy Patient Information

To provide a high standard of health care we need to collect personal information from our patients. This information is usually collected from the patient, but can also be collected from family members and other health care providers. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your clinician.

### Consent

We ask for consent to discuss your case with your other health care providers should that be required to assist in your treatment.

- I consent to the use of my personal health information by The Body Guard clinic and other health providers involved in my medical treatment and health care
- I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment

Signature of patient or guardian..... Date.....