



KOOBIL STREET MEDICAL
PATIENT REGISTRATION FORM – ADULT (16+)

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. The purpose of this questionnaire is to help your doctor to assess your health needs. This information is treated confidentially.

UPDATE OF DETAILS

Title: Dr Mr Mrs Ms Miss Other..... **Gender:** Male/Female/other **Dr:**

Surname: **First Name:**

Preferred Name: **Date of Birth:**

Address:

Suburb: **Post Code:**

Mobile: **Home:** **Work:**

Email: **Occupation:**

Do you want to receive SMS reminders for Appointment times and recalls: Yes/No

Next of Kin: Name: Contact No..... Relationship.....

Emergency Contact: Please tick if same as above otherwise advise below

Name: Contact No: Relationship.....

Medicare Number: _____ Exp: ___ / ___ Ref: _____

Pension/Healthcare Card: Exp: ___ / ___

Dept of Veteran's Affairs: Exp: ___ / ___

Social and Lifestyle

Alcohol: Non-Drinker Drinking. Number per day / per week / per month

Are you concerned about your drinking: No Yes

Smoker: No Yes. Number per day / per week

Have you tried to stop smoking No Yes: Longest time without smoking:

Ceased smoking Date: Number of years smoking:

Drug Use: No Yes: Type..... Frequency.....

Do you consent to uploading your MyHealth Record (PCEHR) YES / NO

Signature: _____ Date: ___ / ___ / _____