



# Sydney CBD Medical Centre & Skin Cancer Clinic

## PATIENT DEMOGRAPHIC REGISTRATION FORM

<b>Title:</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other _____	<b>Surname:</b>	<b>First Name:</b>
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<b>Date of Birth:</b> (DD/MM/YYYY)	<b>Ethnicity:</b> <input type="checkbox"/> Australian <input type="checkbox"/> Brazilian <input type="checkbox"/> British <input type="checkbox"/> Chinese <input type="checkbox"/> Colombian <input type="checkbox"/> Indian <input type="checkbox"/> Italian <input type="checkbox"/> Korean <input type="checkbox"/> Thai <input type="checkbox"/> Other: _____
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Sexuality:</b> <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual		
<b>Are you of Aboriginal or Torres Strait Islander origin?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Aboriginal <input type="checkbox"/> Yes Torres Strait Islander <input type="checkbox"/> No		<b>Individual Healthcare Identifier (IHI) No. :</b>
<b>Medicare Number &amp; Reference No.</b>	<b>#</b>	<b>Ref:</b>
<b>Do you have a Centrelink/Pensioner Concession/Seniors Healthcare Card?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>#</b>
		<b>Expiry:</b>

<b>Unit/Street Number/ Street Address</b>			
<b>Suburb</b>	<b>Postcode</b>		
<b>Mobile Phone No.</b>	<b>Home Phone No.</b>		
<b>Email Address</b>	(PLEASE WRITE EMAIL IN CAPITAL LETTERS)		
<b>Next of Kin</b>	<b>First Name</b>	<b>Last Name</b>	<b>Relationship to you</b>
<b>Emergency Contact</b> <input type="checkbox"/> Same as Next of Kin	<b>First Name</b>	<b>Last Name</b>	<b>Contact Number</b>

<b>ALLERGY: Do you have allergies to any medication?</b> <input type="checkbox"/> Nil known <input type="checkbox"/> Yes. Please elaborate:	
<p style="text-align: center;"><b>MY HEALTH RECORD (MEDICARE CARD HOLDERS ONLY)</b></p> <p>MyHealthRecord allows allergies, significant conditions, medications and immunisation records accessible online by you and other Healthcare Providers.</p> <p>All <b>IMMUNISATION RECORDS</b> at this clinic will be uploaded to MyHealthRecord.</p> <p>Please tick 'No' if you DO NOT wish to have your <b>IMMUNISATION RECORDS</b> updated on MyHealthRecord <input type="checkbox"/> <b>No</b></p>	<p style="text-align: center;"><b>RECALLS &amp; REMINDER SYSTEM</b></p> <p>Our practice has a recall system in place for results that need to be followed up with an appointment. All results are discussed by the Doctor only.</p> <p>We also provide our patients with routine preventive care reminders e.g. follow up immunisations, annual skin checks and cervical screenings etc.</p> <p>Please tick 'No' if you DO NOT wish to have <b>PREVENTATIVE CARE REMINDERS</b> sent to you <input type="checkbox"/> <b>No</b></p>
<b>Significant Past/Active Medical Conditions:</b>	<b>Family History – Any significant family history of illness &amp; cancer?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (Please elaborate on condition and relationship to you)
<b>Occupation:</b>	<b>Alcohol :</b> <input type="checkbox"/> No. <input type="checkbox"/> Yes: ___ Days per week ___ Standard drinks per day
	<b>Tobacco :</b> <input type="checkbox"/> No. <input type="checkbox"/> Ceased smoking <input type="checkbox"/> Yes: Cigarettes ___ per day

For each consultation either by telehealth, telephone or in person, including but not limited to health assessments and management plans, I offer to assign my rights to Medicare benefits to the doctors of Sydney CBD Medical Centre who will render the medical service(s). I understand it is necessary for this Practice to collect personal information from me for the purpose of health management and for associated administrative purposes. I consent to the Practice's Electronic Communication Policy and Privacy Policy on handling patient information. Both can be made available to me on request. I understand that failure to provide this Practice with all the information it needs may restrict its ability to provide the quality of health care that I want. I acknowledge that I have read and understood this form before signing it.

**Signature:** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_