MAYA MEDICAL CENTRE
PATIENT REGISTRATION

Please complete all details so that we may provide you with the best possible care.
All information is kept according to the Privacy Act and is strictly confidential.
Please PRINT or TICK responses where applicable

Title: Ms ☐ Mr ☐ Mrs ☐ Miss ☐ Master ☐ Dr ☐ Other:			
Surname:			
First Name/s:			
Marital Status: Single ☐ Married ☐ De Facto ☐ Divorced ☐ Widowed ☐			
Country of Birth (Ethnicity):		Date of Birth:	
If Australian, are you of Aboriginal or Torres Strait Islander Descent?			
No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Both ☐			
Email Address:			
Home Address:			Postcode:
Postal Address:			Postcode:
Home Phone:			Mobile:
Work Phone:		Preferred Contact: H ☐ W ☐ M ☐	
Occupation:			
Medicare No:	IRN:	Expiry:	
Dept Vet Affairs (DVA):		Expiry:	Class:
Health Care Card No:		Expiry:	
Pension Card No:		Expiry:	
Health Insurance:		Expiry:	
Next of Kin:	Relationship:		Ph:
Emergency Contact:	Relationship:		Ph:
Allergies:			
Current Medications:		Dosage:	
Previous Operations:			
Do you have, or have you ever had, any of the following?			
Asthma ☐ Breast Cancer ☐ Bowel/Colon Cancer ☐ Diabetes ☐ Depression ☐ Epilepsy ☐			
Heart Problems ☐ High/Low Blood Pressure ☐ Kidney Disease ☐ Melanoma ☐ Stroke ☐			
Other (Please give details):			

MAYA MEDICAL CENTRE
PATIENT REGISTRATION

Family History
Mother: is your mother still alive? Yes ☐ No ☐ Unknown ☐
If no, age at passing: Cause of death:
Does she have, or has she ever had, any of the following?
Asthma ☐ Breast Cancer ☐ Bowel/Colon Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐
Heart Problems ☐ High/Low Blood Pressure ☐ Kidney Disease ☐ Melanoma ☐ Stroke ☐
Other (please give details):
Father: is your father still alive? Yes ☐ No ☐ Unknown ☐
If no, age at passing: Cause of death:
Does he have, or has he ever had, any of the following?
Asthma ☐ Breast Cancer ☐ Bowel/Colon Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐
Heart Problems ☐ High/Low Blood Pressure ☐ Kidney Disease ☐ Melanoma ☐ Stroke ☐
Other (Please give details):
Other immediate family members who have, or have had, any of the above illnesses?
Relationship Illness
Social History
Are you a Centrelink Registered Carer: Yes ☐ No ☐
Do you have a Carer: Yes ☐ No ☐
Accommodation: Do you: Own your home ☐ Rent ☐ Homeless ☐ Other:
Who do you live with: Spouse ☐ Family ☐ Friend ☐ Alone ☐ Other:
Alcohol:
Do you drink alcohol: Yes ☐ No ☐ How many days per week? Per day?
Did you previously drink alcohol: Yes ☐ No ☐ was this: Light ☐ Moderate ☐ Heavy ☐
Smoking:
Do you currently smoke: Yes ☐ No ☐ How many per week? Per day?
Did you previously smoke: Yes ☐ No ☐ was this: Light ☐ Moderate ☐ Heavy ☐
By completing and signing this form and becoming a patient at Maya Medical Centre, you consent to the following: I consent to the disclosure and use of my personal information by Maya Medical Centre and any other Health Care Providers and Specialists involved both directly and indirectly in my ongoing care and medical treatment. I consent to receiving recalls and reminders for any future investigations and care as required from the Staff of Maya Medical Centre including leaving a message on my Phone, Email or Mobile. I consent to the uploading of my shared Health Summary to My Health Record.
Name (Please Print):
Signature: (Parent or Guardian to sign if child is under 16 years of age)