CENTRAL HEALTH ALLIANCE
DR PAUL BURFORD
BSc MBBS MAEROMED FRACGP
Provider No.229472AL

PATIENT REGISTRATION FORM

Central Health Alliance staff are committed to providing a holistic approach to your health. To enable us to provide the best possible health care designed around your needs, please fill out the information below. ALL information will be treated with the strictest confidentiality. Thank you for your assistance and we look forward to a long and healthy relationship.

PATIENT INFORMATION

Title	□ Dr	□ Mr	□ Mast	□ Mrs	□ Ms	□ Miss □ Other
Surname:						
First Name:			Middle Name:			
Preferred name			Date Of Birth:			
Home Address:						
Postal Address: (If different from home address)						
Contact Number	Home:		Work:		Mobile	
SMS Reminders:	□ Yes	□ No				
Email Address:						
Marital Status:	□Married	□ De-facto	□ Single	□Widowed	□Divorced	□Separated
Occupation						
Medicare Number		Ref No:		Expiry Date:		
DVA Card:		Colour:		Expiry Date:		
List of DVA Conditions:						
□ Pension □ Health Care Card (HCC):				Expiry Date:		
Next of Kin: (Name, Address, Contact Number) Relationship to Patient						
Emergency Contact:						
Are you Aboriginal or Torres Strait Island Descent?	□ No □ Yes Torres Strait Island □ Yes Aboriginal					

Your cultural background may increase your risk of certain illnesses. To help us provide you with the highest standard of care, please let practice staff know your cultural background and or preferred language:

Cultural Background:	
Country of birth:	
Language spoken at home:	

Updated 15/10/19

New Patient Health History Form

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All questions obtained in the form are strictly confidential and will be used solely for Central Health Alliance Patient Medical Records.

Name:	D.O.B: M ☐ F ☐	Occupation:

Personal Medical History

Do you have Allergies / Adverse Reactions?	Yes ☐ Nil Known ☐	
Name of drug / Food / Product	**Reaction** (e.g. Rash, vomiting)	**Severity**

Recent and Past Medical Conditions:	
☐ Diabetes Type:	☐ Depression
☐ Stroke	☐ Anxiety
☐ Heart Disease	☐ Asthma
☐ High Blood Pressure	☐ Skin Condition Type:
☐ Cancer Type:	☐ Other:

Smoker		
☐ Yes How many per day?	☐ No	☐ Ex-smoker How many per day?

Alcohol Intake		
☐ Yes How many per day?	☐ No	☐ Ex-drinker How many per day?

Family Medical History	
Mother: Alive ? Y / N Age of death:	Father: Alive? Y / N Age of death:

Tick below for conditions that apply – Circle M for mother's side and F for fathers side

☐ Diabetes Type: M / F	☐ Depression M / F
☐ Stroke M / F	☐ Anxiety M / F
☐ Heart Disease M / F	☐ Asthma M / F
☐ High Blood Pressure M / F	☐ Skin Condition Type: M / F
☐ Cancer Type: M / F	☐ Other: M / F

Current Medications: (include prescribed drugs, over the counter and vitamins)

Name of Medication and Dose	Reason Medication being taken	How long have you been taking it?

Recent/Past Surgeries or Hospitalizations	
Year Occurred:	Reason:

Women ONLY	
Contraceptive Use (if using implanon state last insertion date)	
Date of last PAP	
Date of last Breast Screen	
Men Only	
Date of last Prostate Check	

Sign and date below to consent to the above information being uploaded to your CHA patient file.