REGISTRATION APPLICATION FORM

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Name	
Address	
Date of Birth:	
Phone	
PPS	
Male/Female	
Previous GP	
List of Current Meds	
Text Messaging **Texting is not secure, your GP may text medical information. Pls protect your phone, read & delete text messages. Advise GP if phone number changes**	**Do you consent to receiving lab results, details of screening services and appointment reminders via text messaging: Yes / No**
Have you or any member of your family been seen at this surgery before	**Yes / No**
First Language	
Need interpreter:	**Yes / No**
Currently hold a Medical Card	**Yes / No Doctor:**
Do you wish to apply for a medical card?	**Yes / No**

Do you suffer from any of the following:

	Yes	No
Heart Disease / High Blood Pressure		
Diabetes		
Psychiatric Illness		
Cancer		
Allergies		
Other illness / Please specify		

Office Use only

Form given out by:	
Form taken in by:	
Form reviewed by doctor:	
Scanned	

Please note that this form is given directly to our GP in utmost confidence

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We store your medical records electronically at the practice. This includes the information on this form, all medical notes taken at the practice, and reports and correspondence from other health professionals. We sometimes need to share this information with other health professionals. We may be requested by insurance companies, banks, solicitors etc. for copies of some or all of your notes which we will provide on receipt of written consent from yourself. We store your PPSN number to facilitate us in the filling of forms for Social Insurance and other interactions with the government.

We have a Practice Privacy Statement that we can supply on request.

Please sign below to consent to us processing and storing your personal data.

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