Registration Form

ACCESS Health & Community

Thank you for taking the time to complete this form.
Your answers are very important so that we can provide you with the best health care.

Personal Details

Surname (last name): _____

Given name/s: _____

Preferred name: _____

Title: _____

Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Date of birth: / /

Occupation: _____

Home address

Street: _____

Suburb: _____

State: _____ Postcode: _____

Postal address

Street: _____

Suburb: _____

State: _____ Postcode: _____

Are you or your immediate family homeless, or at risk of homelessness?

☐ Yes ☐ No

Contact details

What are your contact details? Can we leave a message?

Mobile: _____ ☐ Yes ☐ No

Home phone: _____ ☐ Yes ☐ No

Work phone: _____ ☐ Yes ☐ No

Email: _____ ☐ Yes ☐ No

Can we send you an SMS reminder? ☐ Yes ☐ No

Contact details

Next of Kin Contact: _____

Contact Number: _____

Relationship: _____

Emergency Contact: _____

Contact Number: _____

Relationship: _____

Do you have an advance care directive for end of life care?

☐ Yes ☐ No

(For more information talk to your GP)

Cultural Background

Cultural Background: _____

Country of birth: _____

Preferred language: _____

Do you need an interpreter? ☐ Yes ☐ No

If yes, which language?

_____

Are you Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Do you have a carer?

☐ I have a carer who lives with me
☐ I have a carer who doesn't live with me
☐ I don't have a carer but I need one
☐ I do not need a carer

If you do have a carer, please fill in their details:

Carer's name: _____

Carer's address: _____

Carer's contact number: _____

Please turn over >

The AccessHC Family of Services Includes:

headspace Hawthorn

HAWTHORN COMMUNITY HOUSE

Camcare Empowering people

trentwood at the hub your local community house

MANNINGHAM MEN'S SHED

We are a child safe organisation.

Registration Form *(continued)*

ACCESS Health & Community

Do you have a Medicare card? ☐ Yes ☐ No

Medicare Card Number: _____

Ref No: _____

Card Expiry Date: / /

If you have one of these cards, please note the number & expiry

- ☐ Health Care Card
- ☐ Pension Concession Card
- ☐ Commonwealth Seniors Health Card
- ☐ DVA
- ☐ Other: _____

Card Number: _____

Card Expiry Date: / /

DVA Number: _____

Medical History

Medications (including injections, vitamins and supplements):

Allergies and reactions:

Pre-existing medical conditions or surgeries:

Lifestyle

Smoking

- ☐ Non Smoker
- ☐ Ex Smoker
- ☐ Smoker: _____ ☐ Day ☐ Week ☐ Month

Current Alcohol

- ☐ Non Drinker
- ☐ Drinker: ____ standard drinks ☐ Day ☐ Week ☐ Month

Family History

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Stroke
- ☐ Asthma
- ☐ Cancer

How did you hear about us?

- ☐ Facebook
- ☐ Google Search
- ☐ Internet
- ☐ Word of Mouth
- ☐ Walk By
- ☐ Other

☐ **I have received a copy of the brochure 'Rights and Responsibilities' and 'Privacy Statement'.**

☐ **I understand that my information may be shared with other staff at AccessHC or to other health professionals to allow quality medical care.**

Signed: _____

Date: _____

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