NEW PATIENT REGISTRATION FORM

Bourke Aboriginal Corporation Health Service (BACHS) is committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate. Having accurate information helps us to identify you and allows us to contact you quickly, especially regarding tests and results.
All your personal health information is kept private and secure as required by the Australian Privacy Principles and BACHS Policies and Procedures.
If you have any concerns or would like support completing this form, please talk to either your GP or the Practice Manager.

SECTION A: PERSONAL DETAIL		
FULL NAME		
ANY PREVIOUS NAMES?		
DATE OF BIRTH		
GENDER IDENTITY	☐ Female ☐ Male ☐ Non-Binary	☐ Gender Diverse ☐ Transgender ☐ or Different Identity
MARITAL STATUS	☐ Single ☐ Married ☐ Defacto	☐ Divorced ☐ Widowed
HOME ADDRESS		
POSTAL ADDRESS (IF DIFFERENT TO ABOVE)		
HOME PHONE NUMBER		
MOBILE NUMBER		
WORK NUMBER		
EMAIL ADDRESS		
PREFERRED CONTACT NUMBER	☐ Home ☐ Mobile	☐ Work
MEDICARE NUMBER		**EXPIRY DATE**
DVA	☐ GOLD ☐ WHITE	**EXPIRY DATE**
PENSION NUMBER		**EXPIRY DATE**
HEALTH CARE CARD NUMBER		**EXPIRY DATE**
OCCUPATION		
CULTURAL BACKGROUND **Knowing your cultural background helps us provide healthcare that meets your individual needs**		
Do you identify as Aboriginal or Torres Strait Islander?	☐ YES	☐ NO
Country of Birth		
Is English your first language?	☐ YES	☐ NO

Specify Language		
Do you need an interpreter?	☐ **YES**	☐ **NO**
Religion		
EMERGENCY CONTACT		
EMERGENCY DETAILS **Please provide details of someone you wish us to contact in case of an emergency**	**NAME**	
	RELATIONSHIP	
	PHONE NUMBER	
NEXT OF KIN ☐ **AS ABOVE**	**NAME**	
	RELATIONSHIP	
	PHONE NUMBER	
SECTION C: CONSENT		
Our practice uses a reminder system/s to help maintain your health. This practice may call, send our reminders via SMS, email for procedures such as PAP smears, health reviews and vaccinations		
☐ **I CONSENT to receiving telephone calls, SMS or email to confirm my appointments**		
☐ **I CONSENT to being contacts for reminders and results to help maintain my health**		
SIGNATURE	**DATE**	