☐ Application ☐ Renewal

National Health Co-op
Better Health Together

Membership Registration Form – Page 1

This registration form is used for several purposes. It comprises information necessary to:

- process your Co-operative membership
- form the basis of your medical record
- register you as a patient
- allow us to contact you when required

Information provided on this form is treated as strictly confidential and will not be provided to any person or entity without your permission. Similarly, it will only be used by the National Health Co-op (NHC) for the purposes listed above. Please review our practice brochure for more detailed information in regards to our privacy obligations.

Title:	Mr Mrs Ms Miss Mast Dr Prof Other:_____	Medicare	Number:
Surname:			Line No: Exp:
Given Name(s):		Pension/HCC No:	
Preferred Name:		Card Type:	
Date of Birth:		DVA No:	
Gender:	Male Female Other Unknown	DVA Card Type:	Gold White

Do you wish to be recognised as:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
What is your marital status?	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ De facto

Home Address:			
Postal Address:			
Phone:	(M) (H) (W)		
Email:		Health Fund:	
Occupation:		Fund No:	
Religion (optional):		Ethnicity:	

Name of emergency contact:	Contact phone number:

Dependants (under 18 years) to be covered under this membership

Name	Date of Birth

CONSENT FOR USE OF INFORMATION: I confirm the information above is correct. I consent to the doctors and staff of NHC, other treating practitioners and allied health providers exchanging all relevant information for the purpose of managing my health. I understand this information will be used by all doctors and staff of the NHC to fulfil their duties in the course of my healthcare planning and management of my health. I consent to receiving information about my healthcare and all NHC member benefits via email, SMS and post.

'FAILURE TO ATTEND' POLICY: A fee may be charged if you fail to attend a scheduled appointment without giving prior notice, or cancel within 2 hours of a scheduled appointment.

By signing this registration form, I acknowledge that I understand the above policy.

Membership Registration Form – Page 2

The National Health Co-op (NHC) is focused on providing the best care to you, from the most appropriate clinician. To provide this level of integrated quality care, it is essential that your health care team know as much as possible about your existing (and past) health and lifestyle. As such, all NHC clinicians involved with your care will have access to your record.

If there are any questions you would rather not answer, please leave them blank.

Do you have any personal or family history of:	Self or family member (E.g. mother, father, etc.):		
• Diabetes		Is your mother alive?	☐Yes ☐No Age at death:
• Hypertension		Cause of death:	
• Heart Disease		Is your father alive?	☐Yes ☐No Age at death:
• Stroke		Cause of death:	
• Colon Cancer		List any known allergies:	
• Breast Cancer		☐ No known allergies	
• Depression		Are you an elite athlete?	☐ Yes ☐ No
• Other (please list)		Do you have a carer?	☐ Yes ☐ No

What previous occupations have you had?	
What recreational activities do you engage in (e.g. walking, jogging) and how often?	

(Please circle answers) Do you currently drink alcohol?	Yes No	How many per day? 1 2-3 4-6 7+	How many days per week do you drink? 1 2 3 4 5 6 7
Past alcohol intake:	Nil Occasional Moderate Heavy	Year started:	Year ceased:
Do you currently smoke?	Yes No	Approx. how many cigarettes per day?	
Past smoking history:	Light Moderate Heavy	Year started:	Year ceased:
Which prescription drugs do you take? (Please list the drug and dosage)			
Which over-the-counter drugs do you take? (Please list the drug and dosage)			

Authorised Person: I authorise the following person to act on my behalf in regards to accessing my records, results and other information that may be held by NHC. I understand that I can revoke this authority at any time by contacting NHC in writing.

Contact Person: _____ Relationship to you: _____

Contact details: (Ph:) _____ (M) _____ (E) _____

Members aged 16 years and over must sign their own registration form.

Name: _____ Signature: _____ Date: / /