



SETAC Primary Health Care & Well-being Centre  
 7393 Channel Hwy, Cygnet Tas 7112  
 Phone: (03) 6295 1125 Fax: (03) 6295 0752 Email: [health@setac.org.au](mailto:health@setac.org.au)  
 Website: [www.setac.org.au](http://www.setac.org.au) Social Media: @setacaus

## Registration Form

### Personal Details

Title (Please circle): Mr / Ms / Miss / Mrs / Other: \_\_\_\_\_  
 Given Name(s): \_\_\_\_\_ Surname: \_\_\_\_\_  
 Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Any Previous Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_ Post code: \_\_\_\_\_  
 Postal Address: \_\_\_\_\_ Post code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Mobile: \_\_\_\_\_ Email: \_\_\_\_\_  
 Medicare \_\_\_\_\_ ( ) Client # Exp Date \_\_\_\_ / \_\_\_\_ Pension Card Number \_\_\_\_\_

### Emergency Contact Details

In case of an emergency, who can we contact?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 His/her relationship to you: \_\_\_\_\_

### Aboriginal or Torres Strait Islander Status

Do you identify as being Aboriginal and/or Torres Strait Islander?

No  Yes, Aboriginal  Yes, Torres Strait Islander  Yes, both Aboriginal and Torres Strait Islander

If yes, would you like to become a SETAC Member (includes Annual General Meeting Suffrage)?  Yes  No

If no, do you have a family member who identifies as Aboriginal or TSI?  No  Yes

If yes, what is their name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

### Consent

Do you consent to SETAC staff using photographs of you and/or your family that can be used in SETAC publication material/Social Media?  Yes  No

Do you consent to relevant information being shared with your GP and health professionals involved in your care i.e. specialists, allied health?  Yes  No

GP Name: \_\_\_\_\_

**Smoker status** (circle) **Yes/ No** **daily/weekly/less than weekly** **Number of Cigarettes** \_\_\_\_\_

**Ex-smoker/never smoked** **Quit date** \_\_\_\_\_ **Duration** \_\_\_\_\_

### Do you have a history of;

**Diabetes**  Yes  No **Type 1**  **Type 2**  **Arthritis**  Yes  No  
**Kidney Disease**  Yes  No **Cardiovascular**  Yes  No if yes, type? \_\_\_\_\_  
**Asthma**  Yes  No **Cancers**  Yes  No if yes, type? \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_