# MONTY & ELTHAM CLINIC

# New Patient Registration Form

## PATIENT INFORMATION

**Title**: ❑ Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Other .....

**First Name** ..... **Surname**..... Preferred Name .....

**Address** .....

**Suburb** ..... **Postcode**.....

**Date of birth** ...../...../..... **Gender:** ❑ Male ❑ Female

**Phone Contact :** **Home** ..... **Mobile** ..... Work.....

**Medicare number** ☐☐☐☐ ☐☐☐☐☐☐ Ref No: ☐ Expires ...../.....

| | |
|---|---|
| **SMS Reminders** | ❑ Yes ❑ No<br>If available would you like SMS reminders regarding your Appointments? |
| **Other Family Members attending the clinic** | |
| **Account payer** | ❑ Self - ❑ Other- Details: |
| **Concessions:** | ❑ Health Care Card ❑ Pension ❑ DVA Gold ❑ DVA White<br>Entitlement Number ☐☐☐☐☐☐☐☐☐ Expiry ..... |
| **Claims** | ❑ TAC ❑ Work cover Claim No: ..... |
| **Are you Aboriginal or Torres Strait Islander ?** | ❑ No ❑ Torres Strait Islander ❑ Aboriginal |
| **Cultural background** | Cultural background .....Country of birth .....<br>Language Spoken ..... Do you require an interpreter? ❑ No ❑ Yes |
| **Contact in case of an Emergency** | Name ..... Relationship .....<br>Phone number ..... Mobile ..... |
| **Next of Kin**<br>❑ Tick if the same as Above | Name ..... Relationship .....<br>Phone number ..... Mobile ..... |
| **Marital status** | ❑ Married ❑ De facto ❑ Single ❑ Widowed ❑ Divorced ❑ Separated |
| **Occupation** | |
| **Disabilities/ Special Needs** | ❑ Vision impaired ❑ Hearing impaired ❑ Other -<br>Details : |



Please turn the page over

# MEDICAL HISTORY

**Do you drink Alcohol ?**

No ❑ Yes ❑

Days per week……number per day…… type……

**Smoker ?**

❑ Never ❑ Ex-Smoker (since)_____

❑ Yes- Current ---------- (Number per day)

**Physical Activities – How often would you do 30 minutes of exercise?**

❑ Daily ❑ Weekly Number……Times per week ❑ Never ❑ Other……..

**Do you have any Allergies?** ( Drug,Tape ,Food etc)

No ❑ Yes ❑

Allery to……

**Women's Health-** Date last Checked for-

Breast Check …… Mammagram ……

Pap smear**……**

**Height** **……**

**Weight** **…….kg**

**Men's Health-** Date of Last Check-up/ PSA ……

**Waist Measurement** **……..**

**Blood Pressure**

**……/……** Last taken**……**

**Past Medical Conditions-**

**Current Medications- Please List**

**Family History**

**Operations. Please List any operations**

**Immunisations- Last vaccine**

| | | | |
|---|---|---|---|
| *Influenza* | ……./…… | *Pneumonia* | ……./……. |
| *Hepatitis A* | ……./……. | *Hepatitis B* | ……/…….. |
| *Measels* | ……../……. | *Rubella* | ……./…… |
| *Meningococcal* | ……./……. | *Thyphoid* | ……./…… |
| *Tetanus* | ……../……. | | |

## HEALTH INFORMATION COLLECTION AND USE

Eltham Clinic aims to protect the privacy and secure storage of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

- Billing purposes and Administrative purposes in running our medical practice.
- Disclosure to others involved in your healthcare
- For research and quality assurance activities (Unidentified) you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

I give consent for my personal information being using in the ways listed above

Signed …… Print Name …… Date……/……./……



Thank you for taking the time to complete this form.

**PLEASE RETURN THIS FORM TO RECEPTION**