279 Gilbert Rd
Preston West 3072

TEL: (03) 9470 1954
FAX: (03) 9471 0558

# NEW PATIENT REGISTRATION FORM

**In order to be able to provide you with the best quality of care, we need accurate information.**
Our practice follows the guidelines of The Royal Australian College of General Practitioners handbook for the management of health information in private medical practice. This means that your personal health information is kept private and secure, as required by federal and state privacy laws.

*** Please Complete Every Section of the Form Below***

Mr
Ms
Mrs ________________________________________ Preferred Name:___________________ Ethnicity: A.T.S.I. / European / Asian / African / Other
Miss
Dr/Prof

Date of Birth ___________ Age ______

Address ______________________________________________________________ Postcode ___________

Ph.: Home ________________ Bus _________________ Mob _________________

Medicare No __________________________Position Number (e.g. 2 )______ Expiry date _____________

Pension/Repat. No. _________________________________ Expiry date _____________________

Health Care Card No _________________________________ Expiry date _____________________

Private Health Fund ☐ No ☐ Yes Fund _________________________ Is the cover ☐ Gold ☐ Silver ☐ Bronze

Occupation ____________________ Employer __________________________Work Telephone No: ___________

**Responsible Person**

**Is the patient responsible for themselves ? Yes: ☐ (skip this section). No: ☐ (complete A B C D below).**

A. Responsible Person Name (s)

B. Address ________________________________________________________________ Postcode ____________ (if different from above)

C. Person 1: Ph.: Home ______________ Mob ________________ Person 2 (if necessary) Ph.: Home ______________

D. Relationship to the patient? (1)____________ (2) ______________ Mob ________________

**Please list two people who could be notified in case of an emergency (not living at home with the patient)**

**1.** Name __________________________ Relationship to patient ____________ **NOK**: **Yes:** ☐ **No:** ☐ **(complete 3)**

Phone: (h)__________________ (m)____________________

2. Name __________________________ Relationship to patient ____________ **NOK: Yes:** ☐ **No:** ☐ **(complete 3)**

Phone: (h)__________________ (m)____________________

3. If these are not your **Next of Kin** – please advise your Next of Kin, in case they need to be contacted also:

Name __________________________ Relationship to patient ____________ Contact Phone: _____________________

**How did you hear about our practice?**

Recommendation by:

☐ Family / Friends ☐ Internet ☐ Specialist ___________________
☐ Signage ☐ Mail out ☐ Chemist ____________________
☐ Local paper ☐ Yellow pages ☐ Other please specify___________

# General Health Information

**Our main focus is to provide the best medical care available. Your lifestyle, ethnic origin, health problems that you may have, and medications that you may be taking -- including OTC, vitamins, and holistic / herbal preparations -- can have an important inter-relationship with your general state of health and future management.**

**For these reasons, we ask that you kindly answer the following questions. (Your answers are for our records only and are confidential).**

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**GENERAL HEALTH HISTORY:** Do you smoke? ☐ No ☐ Yes How many? _________ Do you drink alcohol? ☐ No ☐ Yes

Have you suffered any serious illness or had operations in the past? ______________________________________________

______________________________________________________________________________________

Please indicate if you have a history of any of the following? **High Blood Pressure** ☐ **Stroke** ☐

**Blood clots / thrombosis** ☐ **Diabetes** ☐ **Cancer** ☐ **Heart trouble** ☐ **Emphysema or Chronic Bronchitis** ☐

**Epilepsy** ☐ **Kidney disease** ☐ **Hepatitis / HIV** ☐ **Bleeding tendency** ☐ **Other Lung disease** ☐

**Depression/Anxiety** ☐

**RESPIRATORY SYMPTOMS:** ☐ **No** ☐ **Yes (circle all that apply) Cold, Cough, Shortness of breath, Fever, Sore throat, Headache.** **Have you had contact with anyone with Coronovirus or Influenza?** ☐ **Yes** ☐ **No**

**MEDICATION:** If you are currently taking medications, please detail ______________________________________________

______________________________________________________________________________________

**ALLERGIES:** Are you allergic to any ***medicines or tape*** - please list ______________________________________________

**General Allergies (eg Foods/Beestings etc)** ______________________________________________

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**PATIENTS PLEASE NOTE**

Patients are advised that The Clinic 279 is a Private General Practice and currently bills patients at fees that reflect the AMA recommended fees. The AMA recommends fees based on what is fair and reasonable, but patients are reminded that these are beyond the standard rebate provided by Medicare. A standard consultation takes up to 10-15 minutes. Consultations longer than 20 minutes attract a higher fee and a higher Medicare rebate. A full list of fees is available for your perusal on request. Rising costs including medical indemnity costs necessitate increases in fees from time to time.

**The terms of contract are settlement of all consultation accounts on the same day.**
**Please note that cancellations of appointments require 24 hours notice.**

**For children 16 years and younger, DVA patients and Holders of Current Pensions and Health Care Cards**, this practice will accept the Medicare Rebate via bulk-billing as full payment of the fees. This represents around a 50% discount on the AMA recommended fee. **This may be subject to change without notice.**

**If you do not have a current Centrelink Card, how would you prefer to settle your account?**

**Cash** ☐ **Credit card** ☐ **Cheque** ☐ **EFTPOS** ☐

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**Privacy Patient Information**

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

***Signed by patient:*** ______________________________ ***Date:*** ______________

In signing, you understand and agree to the terms stated and confirm the above information to be true & accurate.

Office use only: Doctor Consulted (initials) ____________