Bacchus Marsh Medical Centre

New Patient Registration

NAME & CONTACT DETAILS

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Name: Surname:

Date of Birth: Country of Birth:

Occupation:

Address:

Postal Address:

Phone Numbers: (H) (M) (W)

Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Aboriginal ☐ Torres Strait Islander

Cultural Background:

EMERGENCY CONTACT

Name:
Relationship to you:
Phone Numbers: (H) (M) (W)

BILLING DETAILS

Please tick if you have any of the following

☐ Medicare Card	Number:	Ref:	Expiry:
☐ DVA Gold Card	Number:		Expiry:
☐ DVA White Card	Number:		Expiry:
☐ Pension Card	Number:		Expiry:
☐ Health Care Card	Number:		Expiry:

Continued over the page…..

Current Regular Medications:	
(including all over the counter medications/vitamins etc)	- - - - - -

Allergies:	
(Include reaction)	☐ Nil known - -

History:	
Active Current medical issues	- - - - - -
Inactive (past operations, illnesses and injuries)	- - - - - -

Alcohol:	
Current:	☐ Non drinker Days per week: ____ Drinks per session: ____
Past:	☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Smoking:	
Current:	☐ Non smoker ☐ Ex Smoker ☐ Smoker Quantity per day: _____ Year started: _____
Past: (If applicable)	Year stopped: _____ Quantity per day: _____

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Social History:			
Marital Status:	☐ Single ☐ Separated	☐ Married ☐ Divorced	☐ Defacto ☐ Widowed
Sexuality:	☐ Heterosexual	☐ Homosexual	☐ Bisexual

Family History:			
	☐ Unknown (eg. Adopted) ☐ No significant family history		
Mother:	Alive ☐ Yes ☐ No Age at death: _____ Cause: _____		
	☐ Diabetes ☐ Stroke ☐ Breast Cancer	☐ Hypertension ☐ Colon Cancer ☐ Other:	☐ Heart Disease ☐ Depression
Father:	Alive ☐ Yes ☐ No Age at death: _____ Cause: _____		
	☐ Diabetes ☐ Stroke ☐ Other:	☐ Hypertension ☐ Colon Cancer	☐ Heart Disease ☐ Depression

NEW PATIENT CONSENT FORM

Y / N I consent to receiving recalls and reminders regarding my personal health care and medical treatment

Y / N I consent to the use of my personal health information by Bacchus Marsh Medical Centre and other health providers involved in my medical treatment and health care

Y / N I consent to the disclosure of my personal health information by the Bacchus Marsh Medical Centre to other health providers involved in my personal health care or medical treatment

Y / N I consent to the use of my de-identified information for research purposes

Signature: _____

Parent / Guardian Name: _____

Date: _____