Bacchus Marsh Medical Centre

New Patient Registration

NAME & CONTACT DETAILS

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

First 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? ☐ Yes ☐ No

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:

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MEDICATIONS

Please list all current medications including vitamins, herbal medicine and over the counter medications and doses if known

ALLERGIES

Please list any known allergies

HISTORY

Please list any medical history and past operations, illnesses and injuries

IMMUNISATIONS

☐ Childhood vaccines up to date
☐ Pneumococcal (Pneumonia) Date:
☐ Influenza Date:
☐ Tetanus Date:
☐ Other (Please specify) _____ Date:

WOMEN'S HEALTH:

Last Pap Smear:
Last Mammogram (If over 50):

MEN'S HEALTH:

Last Prostate Check (If Over 50):

LIFESTYLE HEALTH HISTORY:

Smoking:
☐ Never
☐ Ex-Smoker – quit date:
☐ Current smoker - __ per day

Alcohol:
☐ Non-Drinker
☐ Rarely/Light
☐ Moderate
☐ Heavy

FAMILY HISTORY

Diabetes	☐ Mum	☐ Dad	☐ Other	
Heart Disease	☐ Mum	☐ Dad	☐ Other	
Stroke	☐ Mum	☐ Dad	☐ Other	
Asthma	☐ Mum	☐ Dad	☐ Other	
Depression	☐ Mum	☐ Dad	☐ Other	
Cancer	☐ Mum	☐ Dad	☐ Other	Please specify type:

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NEW PATIENT CONSENT FORM

Patients Name: _____

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: _____