NEW PATIENT REGISTRATION FORM

DIAMOND VALLEY CLINIC

126 Hurstbridge Road, Diamond Creek

Please ensure you complete all sections of this form and hand into reception

Title: .... Given Name(s):.. Surname: .... Gender: ....

Date of Birth: ______/______/______ **Residential Address:**____

____

Home Ph: ________________________

Mobile: ________________________

Work: ________________________

Please TICK preferred contact number

Postal Address: ***(If Different)*** ____

____

Email: ____

Country of birth: ______________________________ *Ethnicity:* ______________________________

(Please Circle) ***Are you*** *Aboriginal* *Torres Strait Islander* *Aboriginal & Torres Strait Islander*

Will you be a permanent patient of this practice? Y / N *If yes would you like you records transferred over from your previous practice?* Y / N *(If so please complete additional form)*

MEDICARE No: ☐☐☐☐☐☐☐☐☐☐ **Patient No:** **Expiry Date: /**

HCC or Pension Card No: **Expiry Date: / /** **Vet Affairs No:**

Do you have a My Health Record Y / N / Unsure

NEXT OF KIN: ________________________________

Relationship: ________________________________

Contact No: ________________________________

(If different to NOK)

EMERGENCY CONTACT: ________________________

Relationship: ________________________________

Contact No: ________________________________

FOR CHILDREN UNDER 16 YEARS OF AGE

Parent / Guardian Name: ____ DOB: ______________________

Address: ____

Medicare Number: ____________________________ Patient No: ________________ Expiry: ________________

I acknowledge payment is required at time of consultation. Please Initial ....

Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff. We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below. Diamond Valley Clinic collects information from you for the primary purpose of providing quality health care. The provision of quality health care requires a doctor –patient relationship of trust and confidentiality. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:
Administrative purposes in running our medical practice. Billing purposes, including the compliance with Medicare Australia requirements.
Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals. To contact you or your family for the purposes of recalls and reminders.

To comply with legislative requirements e.g.: notifiable diseases. Patient information shall not be released to a third party without the consent of the patient.
I have read the information above and understand the reason my information is collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained

Name: .... Sign: ....Date: ....

(Parent / Guardian to sign if under 16)

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MEDICAL HISTORY

Do you have any known allergies? Y / N

If so, please list below, and describe reaction to each allergy:

____

____

____

____

____

____

____

____

Please list ALL current medications (including herbal/therapeutic)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

OTHER MEDICATION:

Please list ALL current and past medical conditions:

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

Please circle ALL that apply to you

Heart disorders	Asthma	Blood Pressure
Blood Disorders	Kidney Disease	Epilepsy
Arthritis	Migraine	High Cholesterol
Depression	Diabetes	**Do you consume alcohol? Y / N**

Do you smoke? Y / N **How many years?** **How many per day?** **If ceased, when?** ___________

FAMILY HISTORY

(eg: Diabetes, blood pressure, cancer, depression, cause of death)

Mother: ______________________________________

Father: ______________________________________

Siblings: ______________________________________

Children: ______________________________________