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:** _____ **Date of Birth:** _____/_____/_____

(Please Circle) **Birth Sex:** Female/Male/Intersex **Pronouns:** He/His/Him She/Her/Hers They/Them/Their

Gender Identity: Female/Male/Non-Binary/Gender Diverse/Transgender/Different Identity: _____

Residential Address: _____

Home Ph: _____ ☐

Mobile: _____ ☐

Work: _____ ☐

Please TICK preferred contact number

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

_____

Email: _____

Country of birth: _____ *Ethnicity:* _____ *Occupation:* _____

(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

(If different to NOK)

NEXT OF KIN: _____ EMERGENCY CONTACT: _____

Relationship: _____ Relationship: _____

Contact No: _____ 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 ……

Diamond Valley Clinic Pty Ltd (CAN 061 658 955) as trustee for Diamond Valley Clinic Unit Trust (**Diamond Valley Clinic)** is committed to supporting doctors to provide you with high quality patient care, Diamond Valley Clinic, and your treating doctor, require your consent to collect, use and disclose personal information (including sensitive information) about you. The collection of this information is reasonably necessary for the activities of Diamond Valley Clinic and your treating doctor. This information is also required to provide accurate medical diagnosis, appropriate treatment and to be proactive in your healthcare needs. To ensure quality and continuity of patient care, your personal information (including sensitive information) may be shared by and between Diamond Valley Clinic and medical practitioners who treat patients at Diamond Valley Clinic, and with other external healthcare providers and administrators (e.g., radiologists, pathologists, specialists outside of this medical practice, and public or private hospitals) from time to time. We do not anticipate that your personal information will be provided to any overseas recipients.
(More detailed information about the way Diamond Valley Clinic and medical practitioners who treat patients at the practice use and disclose your personal information is set out in our privacy Policy which is available at the clinic or on our website: www.dvclinic.com.au).

Please address all requests or questions about how we deal with your personal information, requests for access to your information to:
Practice Manager
Diamond Valley Clinic
126 Hurstbridge Road
Diamond Creek VIC 3089
Phone: 03 9438 3888 Email: reception@diamondvalleyclininc.com.au

PATIENT CONSENT
I have read this privacy collection notice carefully and I consent to the collection of my personal information by Diamond Valley Clinic and my treating doctor, and the use and disclosure of that information by them in accordance with this notice and Diamond Valley Clinic privacy Policy.
I understand that I am not obligated to provide any information requested of me, but that my failure to do so might compromise the quality of health care and treatment given to me.

Name: _____ Signature: _____ Date: _____

(Please Print Name)

If signed by legal guardian, please print name: _____

NEW PATIENT REGISTRATION FORM

DIAMOND VALLEY CLINIC

126 Hurstbridge Road, Diamond Creek

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 <u>past</u> medical conditions:

- _____
- _____
- _____
- _____
- _____
- _____

Please circle <u>ALL</u> 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: _____