DIAMOND VALLEY CLINIC

NEW PATIENT REGISTRATION FORM

126 Main Hurstbridge Rd
Diamond Creek, 3089

Ph: 03 9438 3888
Fax: 03 9438 3339

PATIENT INFORMATION

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____ /_____ /_____ Birth Sex: Female ☐ Male ☐ Intersex ☐

Residential Address: _____ Suburb: _____

Post Code: _____

Postal Address: (If Different) _____ Suburb: _____

Post Code: _____ Preferred Language: _____

Country of Birth: _____ Ethnicity: _____ Occupation: _____

Email Address: _____

Mobile: _____ Home Phone: _____ Work Phone: _____

Consent to receive SMS communications, inlcuding recalls & reminders (No advertisements) Yes ☐ No ☐

Are you of Aboriginal and/or Torres Strait Islander origin?

- ☐ Australian, non indigenous
- ☐ Aboriginal but not Torres Strait Islander
- ☐ Torres Strait Islander but not Aboriginal
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Other

Pronouns:

- ☐ She/Her/Hers
- ☐ He/Him/His
- ☐ They/Them/Their
- ☐ Prefer not to say

Gender Identity:

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Gender Diverse
- ☐ Transgender
- ☐ Different Identity

MEDICARE CARD DETAILS

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ IRN: ☐ Expiry: _____ / _____ / _____

CONCESSION CARD DETAILS

Card Type: Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card ☐

Card Number: ☐☐☐☐☐☐☐☐☐☐ Expiry: _____ / _____ / _____

DVA CARD DETAILS

Card Colour: Gold ☐ White ☐ Card Number: ☐☐☐☐☐☐☐☐☐ Expiry: _____ / _____ / _____

NEXT OF KIN DETAILS

Name: _____

Relationship: _____

Contact Number: _____

EMERGENCY CONTACT DETAILS

Name: _____

Relationship: _____

Contact Number: _____

FOR CHILDREN UNDER 16 YEARS OF AGE

Parent / Guardian Name: _____ Date of Birth: _____ /_____ / _____

Address: _____

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ IRN: ☐ Expiry: _____ / _____ / _____

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MEDICAL HISTORY

Do you have any known allergies? Yes ☐ No ☐ If so, please list below:

Allergy	Reaction/Treatment
1.	
2.	
3.	
4.	

Please list **ALL** current medication (Including herbal/therapeutic):

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

Please list **ALL** current and past medical conditions:

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

Please tick **ALL** that apply to you:

☐ Heart Disorder	☐ Asthma	☐ Blood Pressure
☐ Blood Disorder	☐ Kidney Disease	☐ Epilepsy
☐ Arthritis	☐ Migraines	☐ High Cholesterol
☐ Depression	☐ Diabetes	☐ Anxiety

SMOKING AND ALCOHOL HISTORY

Do you smoke? Yes ☐ No ☐ If so, how many years? _____ How many per day? _____ If ceased, when? _____

Do you consume alcohol? Yes ☐ No ☐ If so, how many standards per day? _____ How many standards per week? _____

FAMILY HISTORY

Eg - Diabetes, blood pressure, cancer, depression, cause of death.

Mother: _____

Father: _____

Siblings: _____

Children: _____

PATIENT CONSENT AND ACKNOWLEDGEMENT

I acknowledge payment is required at time of the consultation (Please sign) _____

Name: _____ Signature: _____ Date: _____

If signed by parent or legal guardian, please sign here: _____

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.