**YARRA VALLEY CLINIC**

**PATIENT REGISTRATION FORM**

**Title: Mr Mrs Ms Miss Mst Other\_\_\_\_\_\_\_\_ GENDER: Male Female Other \_\_\_\_\_\_\_\_\_\_**

**Marital Status:** **(Circle) Married / Single / Defacto / Divorced / Widow**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: | |  | | | | | | | |  | | |
|  | |  | |  | | | | |  |  | | |
| Given names: | |  | | | | | | | | Date of Birth: **……**/…./…… | | |  |  |
|  | |  | |  | | | | |  |  | | |
|  | |  | |  | | | | |  |  | | |
| Address: | |  | | | | | | | | | | |
|  | |  | |  | | |  | | |  | | |
| Suburb/Town: | |  | | | | | Post Code: | | |  | |  |
|  | |  |  | | | |  | | |  | | |
| Telephone: | | Home No. |  | | | | Work No. | | |  | | |
|  | |  |  | | | |  | | |  | | |
| Mobile No: |  |  | | |  | | | **SMS CONSENT – for Appointments, Recalls,**  **Results & Health Information DECLINE** | | | | |
|  |  | | |  | | |
| **Aboriginal - Yes No**  **Torres Strait Islander – Yes No**  **Aboriginal & Torres Strait Islander - Yes No**  **COUNTRY OF BIRTH: ...…………………................** | | | | | | **Is English your first language? - Yes No**  **Please specify Language: ………………………………….**  **Do you require an interpreter? Yes No** | | | | | | |
|  | | | | | |  | | | | |  | |
| **Occupation:** | |  | | | | **Email Address:** | | | | |  | |

**BILLING INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicare Card Number | <Number next to name. **Expiry Date:** .……/…… | | |  |
|  |  | | |  |
| Pension/HCC Card Number | **Expiry Date:** …/.../….. | | |  |
|  | |  | | |
| DVA Number |  | | Private Health Insurance? No Yes Fund: ……………… | |
|  | |  | | |

**CONTACTS**

**Next of Kin:………………………………………………… Relationship to you …………………….Ph:…………………..**

**Address……………………………………………………………………………………... Post Code: …………………. …..**

**Emergency Contact : ……………………………………..Relationship to you …………………….Ph:………………….**

**Address ……………………………………………………………………………………… Post Code: ………………………**

**ALLERGIES**

**Please list any allergies (include reactions to adhesive tapes if any)**

|  |  |  |
| --- | --- | --- |
| Penicillin | Other Medications | Eggs |
| Nut allergy | Immunisation | Bee/Wasp/Ant Sting |
| Medication | Dressings/Elastoplast/Latex | Other ………………………. |

*\**  **NO KNOWN ALLERGIES (please tick)**

**MEDICAL HISTORY**

**\***  **NO SIGNIFICANT MEDICAL HISTORY OR Please list any operations/previous serious illnesses:**

**……………………… ……………………… ………………….. ……………………… ………………………**

**……………………… ……………………… ………………….. BLOOD GROUP (if known): ......................**

**Do you have or have you had a past history of any of the following medical conditions:**

** Asthma**  ** Epilepsy  Diabetes  High Blood Pressure  Heart Disease**

** Stroke  Colon Cancer  Depression  Breast Cancer  Other....................................**

**FAMILY HISTORY**

**Mother alive? Yes /No Age at death: …….. Cause of death: …………………………… (If Known)**

**Father alive? Yes / No Age at death: …….. Cause of death: …………………………… (If Known)**

**Mother:  Diabetes** ** High Blood Pressure** ** Heart Disease  Stroke**

** Colon Cancer** ** Depression** ** Breast Cancer  Other ………………**

**Father:  Diabetes  High Blood Pressure  Heart Disease  Stroke**

** Colon Cancer  Depression  Breast Cancer  Other ………………**

**SOCIAL HISTORY**

|  |  |
| --- | --- |
| **Smoking** - Current Smoking History | **Alcohol** – Non Drinker **OR** |
| Non Smoker Smoker  Ex-Smoker | **ALCOHOL INTAKE** ………Days per week  ……… Standard drinks per/day |
| Year Started …….Year Ceased……… | Year Started …….. Year Ceased……… |

**Lives with:  spouse/ relative/ friend/ alone  Has Carer (Name/Mobile): ……………………… Is Carer:**

**IMPORTANT –**

**THIRD PARTY AUTHORITY:** Should you wish for your spouse/partner or a third party to obtain information regarding appointments, accounts, prescriptions, pathology results on your behalf, a third party authority form will be required to be completed to allow them to do so.

This is also required if you will be calling on behalf of any children aged 14 years and over.

**PAYMENT REQUIRED AT THE TIME OF CONSULTATION:** Our practice requires payment for the consultation on the day of your appointment. Your account will be transmitted to Medicare for processing and your refund will be deposited in the bank account you have registered with Medicare.

Our preferred method of payment is cash, EFTPOS or Credit Card.

**ONLINE BOOKINGS:** Appointments can be made online at **www.hotdocs.com.au** for existing patients of the practice. Confirmation of the appointment will be sent by SMS. Queries or changes to online bookings can made by phoning the practice on **03 5962 4633**.

**CONSENT**

The personal health information you provide during your consultation and subsequent treatment will be collected for the purpose of providing high quality health care. This clinic is committed to protecting your privacy and this information is generally only disclosed to other members of your treating team where necessary, for example, specialists, hospitals, pathology/radiology services and Medicare. For this purpose we need to be able to verify your signature as you will be required to consent to this release.

Information may also be disclosed to other organisations where required by law.

I, (person completing form) …………………………………………………., have read and understand the above practice policies and agree to abide by these policies.

Signed…………………………………………………………….Date: …………….