New Patient Registration Form

This information is private and confidential and is for use in your clinical file only. It is a requirement that all files contain this information for accreditation purposes. Please give as much detail as possible to assist us to provide quality care.

Patient Details: Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mast ☐ Mr ☐ Dr Other:______________

Surname Name: _________________ First Name:_______________________ Preferred Name: _____________

Date Of Birth:___/___/_____ Gender: ☐ Female ☐ Male Other ____________________________

Ethnicity and/or Country of Birth: ____

Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes

If Yes: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both, Aboriginal and Torres Strait Islander

If yes: are you registered for CTG payment? ☐ Yes ☐ No

Residential Address: ____

Town:____ State:___________________ Postcode:____________

Postal Address: (If different to home)____

Home Phone:________________Mobile:_________________________Email:___________________________

Medicare Care Number:____________________________ Ref #.(next to name) _______Expiry:______________

Pension/Healthcare Card (Please circle) Number:_____________________________ Expiry:_______________

Veterans Affairs No: ____________________ ☐ Gold ☐ White- conditions:___________________________

What is your Occupation?____ ☐ Retired ☐ Child

How would you like us to contact you? ☐ Mobile Ph ☐ Home Ph ☐ Email ☐ Post

Can we put your name on a formal reminder system for preventative care? ☐ Yes ☐ No

Do you consent to SMS reminders/recalls: ☐ YES ☐ NO

Next of Kin:______________________Relationship:______________________Phone:___________________

Current Medications:

____

Complimentary Medications: (eg, Multivitamin, supplements etc) ____

Do you have any known allergies? ☐ NO ☐ YES:____

Social History:

Smoking History: ☐ Never smoked ☐ Ex- smoker ☐ Current smoker (how many per day)_________________

Do you drink alcohol: ☐ NO ☐ YES: If yes, how many standard drinks per day? _____________________

PLEASE TURN OVER

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Patient History:

Please list any operations or previous illnesses:____

____

Do you know your blood group? ☐NO ☐YES **If yes, what group are you?**________________

FEMALE PATIENTS: Have you ever had a pap smear?☐ NO ☐ YES **Month:**__________ **Year:**__________

Are you currently Breastfeeding? ☐ NO ☐ YES

FAMILY HISTORY: ☐ Unknown ☐ No significant family history

Mother: Still alive ☐ Yes ☐ No **If No,** Age at Death: _____Cause of Death:_________

Diabetes Hypertension Heart Disease Stroke

Depression Colon Cancer Breast Cancer Other Cancer (Please Specify)____________

Father: Still alive ☐ Yes ☐ No **If No,** Age at Death: _____Cause of Death:_________

Diabetes Hypertension Heart Disease Stroke

Depression Colon Cancer Breast Cancer Other Cancer (Please Specify)____________

Other **immediate** family member's **significant illness:** ________________________________

Are your immunisations up to date? ☐**YES** ☐ **NO** ☐ **Unsure**

Children's Immunisations- If completing this form for a child, are their immunisations up to date?☐ Yes ☐NO

How did you hear about us? ☐**Health Engine** ☐**Website** ☐**Facebook** ☐**Google Search** ☐ **Brochure**

Other:____

At Eclipse Medical Centre we strive to provide high quality care and meet our client's health care requirements.

Please note our practice has a policy of <u>not</u> prescribing drugs of addiction to first time patients.

Privacy Statement:

Eclipse Medical have a no show/cancellation policy. If you no longer require your appointment please call us to cancel, failure to do so 2 hours prior to your appointment may incur a fee of $78.00 which is <u>not claimable</u> with Medicare.

This Practice is a private billing practice, and you will be required to pay accounts at the time of service.

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

☐ **I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE**

Signature:____ Date: ___/___/____