Aspendale Clinic New Patient - Registration Form

The Doctors and Staff at Aspendale Clinic are committed to whole patient care, including preventative and ongoing care. To assist us to maintain your wellbeing, please complete **all** sections of this form. All information collected will remain confidential. When you register as a patient at our practice your doctor and/or support team will need to access your personal information in order to provide the best possible healthcare. **Do you consent to this please circle YES NO**

Please complete all sections clearly and return to reception with Medicare and HCC/ Pension (if applicable) cards.

Medicare card Number: ______________________ ***Reference no:*** ____________

Health Care Card Number: ______________________ ***Expiry Date:*** ____________

Pension Card Number: ______________________ ***Expiry Date*** ____________

Mr / Mrs / Ms / Miss First Name: ______________________

Family Name: ______________________

Maiden Name: ______________________ Gender: M / F / T

Date of Birth: ______________________

Address: ______________________

Suburb: ______________________ P/code: ____________

Home Phone: ______________________ Mobile: ______________________

Email Address: ______________________

Who do you live with?: ______________________ How many children do you have?: ____________

Marital Status: ____________

Next of Kin: ______________________ Gender: M/ F / T

Relationship: ______________________ Phone: ______________________

Emergency Contact: ______________________ Gender: M / F / T

Relationship: ______________________ Phone: ______________________

- **Tick if emergency contact is the same as next of kin**

Please circle: Are you Aboriginal / Torres Strait Islander **Yes / No**

Occupation: ______________________

How did you hear about us? ______________________

Country of birth: ______________________ Year of arrival: ____________

Self-identified ethnicity: ____________

PLEASE TURN OVER........

Please list current medications:

____

____

○ **Tick if not taking any medications**

Please list any allergies:

____

____

Reaction:

____

Please list any operations / previous illness: ______________________

○ **Tick if no significant medical history**

Do you currently smoke: **Yes / No** How many per day:__________

Are you an ex-smoker: **Yes / No** Quit date: ______________

Do you drink alcohol: **Yes / No** How many per day: __________

Have you ever had or have any of the conditions below? **If yes, please circle**:

Diabetes Kidney Disease Asthma

Bowel Cancer Breast Cancer High Blood Pressure

Heart problems Epilepsy

Other:____

____

Is there a **family history** of any of these conditions? If yes, please state relationship

Diabetes Kidney Disease Asthma Bowel Cancer

Breast Cancer High blood Pressure Heart problems Epilepsy

Other: ____

Relationship to you (mother / father / grandparent etc):

____

Name: ______________________ **Signature:** ______________________

Date: ______________

Aspendale Clinic 147 Station Street, Aspendale 3195

Ph: 03 9580 1200 fax: 03 9587 5629

www.aspendaleclinic.com.au