



NEW PATIENT REGISTRATION FORM

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Form with fields for Title, Surname, First Name, Date of Birth, Marital Status, Street Address, Suburb, Post Code, Home Phone, Mobile, Email, Occupation, Medicare Number, Health care Card Number, Pension Number, DVA Number, Card Type, and Expiry Date.

CULTURAL IDENTITY section with text: Knowing your cultural background can help us provide healthcare that meets your individual needs. TO ASSIST WITH HEALTH INITIATIVES - DO YOU IDENTIFY YOURSELF AS: Aboriginal, Torres Strait Islander, Both, Neither. Country of Birth and Ethnicity fields.

EMERGENCY CONTACT DETAILS section with fields for Name, Relationship to you, Home Phone, Mobile Phone, and EMERGENCY CONTACT (if different to above) with Mobile and Home Landline Phone fields.

HEALTH PROMOTING AND PREVENTATIVE CARE: Preferred method of contact section with checkboxes for SMS, Mobile phone, Home phone, Letter, and Email.

Consent section: Do you consent to the following? Information to be sent to Government Registers e.g., Cervical screening (pap) and immunisation, SMS appointment reminders and test results, Uploading clinical documents to My Health Record?, Sharing of NON-IDENTIFIABLE data with our local Primary health Network, Health promotion and preventative care reminders by post, email, telephone, or SMS?

How did you hear about us? section with checkboxes for Google, social media, HOTDOC, Health Engine, Walking past clinic, and Other (please state).

### MEDICATIONS AND SOCIAL HISTORY

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other “natural” remedies or supplements

**CURRENT MEDICATION:**

ARE YOU VACCINATED AGAINST COVID-19 VIRUS?       YES       NO

DO YOU HAVE ANY ALLERGIES?       YES (please list below)       NO

**PREVENTATIVE HEALTH: Please tick the boxes where appropriate**

Height:	Weight:
Smoking <input type="checkbox"/> No <input type="checkbox"/> Ceased - date _____ <input type="checkbox"/> Yes - how many _____ day / _____ week	Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes - how many _____ day / _____ week / _____ month
Bowel Screening Date:	Skin Check Date:
<b>FEMALES</b>	<b>MALES</b>
Pap smear Date:	Mammogram Date:
	Prostate check Date:
	Health check Date:

**MEDICAL DOCTORS IS A PRIVATE BILLING PRACTICE.**

*BULK-BILLING IS NOT ROUTINE: you will receive an account for your visit which must be paid on the day of consultation. Payments can be made by eftpos or credit card. However Bulk Billing applies Only to Children under 16yrs of age, Health care card holders, Pension card holders and DVA card holders, between 8am-5pm Monday-Friday.*

*Certain medical examinations – such as medicals, legal reports & commercial driver’s licences are not claimable from Medicare. If you require any further information regarding cost of these please ask reception staff.*

*Full Payment is required on day for Workcover claims that do not currently have a claim number. You are then able to follow this up with your claim agent.*

**Privacy:**

*Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare services, it is important that you are aware of how any personal information collected by this practice is used.*

*The personal information collected is that deemed necessary to best attend to and treat the presenting health condition(s). Personal information is primarily used within the practice, but sometimes it is used to ensure quality and continuity of health care for you and must be partially or fully disclosed to others outside of the organisation, depending on the circumstances. e.g.: when referring to a specialist medical practitioner or when requesting blood tests, urine tests, x-rays etc., when itemising accounts for Medicare.*

**Freedom of information:**

*All patient files that include personal information, test results etc. are the property of this practice. However, should you choose to visit another Doctor at any time, copies of the appropriate files can be forwarded on receipt of your written request.*

*Under no circumstance will this practice divulge personal information without your prior written consent.*

**Vic Medical Doctors has a zero tolerance towards violence and aggression towards team members.**

**Cancellation/No show Policy:**

*We understand that unplanned issues can arise, and you may need to cancel an appointment. Should this occur, we respectfully ask that scheduled appointments are cancelled at least 24 hours in advance. A cancellation fee of \$75.00 may apply if inadequate notice is given.*

*Please return completed form to reception. Thank you*

I have read & understand all information provided above regarding fees, privacy & freedom of information.  
I also am aware that at the conclusion of all consultations there will be a request for full payment of the account.

PATIENT NAME:	SIGNATURE:	DATE:
<b>(Patient unable to sign OR Underage complete below)</b>		
GURDIAN NAME:	SIGNATURE:	DATE: