BAY VILLAGE MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM - Please complete front and the back of this form

Title: **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Mast** ☐ **Dr** ☐

Surname :……..

First Name/s : …… (as shown on Medicare card) ***Preferred Name:*** ……

Date Of Birth: ……. /…… /…… **Gender**: **Male** ☐ **Female** ☐ **Gender Diverse** ☐

Do you identify as: Aboriginal ☐ **Torres Strait Islander** ☐ **Australian Non- Indigenous** ☐

Another Birth Place ………

Address: ……

Suburb: …… **Postcode**: ……

Contact Numbers: Home: …… Mobile: ……..

Occupation: ……

We have brochures at our front reception - Practice Fees with out of pocket costs - Privacy Policy how we protect your medical information – How you can Communicate with your doctor

SMS Consent Options: PLEASE USE THE TICK BOXES

☐ **Appointments** (SMS notifications to remind you of upcoming appointments with this practice as well as allowing to confirming your appointment) **Online Appointments are also available**	☐ **Clinical Reminders** (to remind you to contact this practice to arrange appointments for regular clinical check-ups, skin cancer procedures and other minor surgery, immunisations due, Care Planning and over 75 Health Assessments. Mammograms & Bowel Cancer and Cervical Smears
☐ **Clinical Results from tests (**communications to you about your clinical care at this practice such as pathology radiology results or clinical messages from your medical practitioner)	☐ **Health Awareness** (relating to general healthcare information and health care services provided by this practice including notification about changes to our clinic opening hours)

Email: ……

Medicare # ☐☐☐☐ ☐☐☐☐☐ ☐ **Ref**: ☐ **Exp.** Date: …… /……

Do you hold any of the following cards:

Pension ☐ or **HCC** ☐ **Card #** ☐☐☐☐☐☐☐☐☐☐ Exp. Date: …… / …… / ……
(please tick)

DVA Card # ☐☐☐☐☐☐☐☐☐ (please tick) Gold **Card** ☐ (please tick) White **Card** ☐

Next of Kin: ……

Phone: _____ **Relationship**: _____

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Emergency Contact: …… **Phone**: ……

Relationship……

Name/Phone number of Previous GP: ……

List any Allergies……

Smoking Status: Non - Smoker ☐ Smoker ☐

Alcohol intake: Non-drinker ☐ or Drinks per day .....

Please list all current medications (including over the counter, herbal or other preparations as well as prescribed).

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Current health problems:

.....

.....

Family History of illness (eg heart, BP, diabetes, stroke, arthritis, asthma, depression, other)

Mother: ..... **Father**: .....

Past Operations or significant illness (if any):

.....

.....

Last Tetanus injection: ……

Immunisation history: (for children) ……

Acknowledgements and Consent:

Please read the information on this form carefully. You are under no obligation to provide consent to the use of your personal information. In the event that you do not consent, we will respect your decision.

- I acknowledge and agree that in the course of providing health care services to me, this practice may need to use and disclose my personal information (including any health information) as set out in this form.
- I understand the National Privacy Principles will be upheld at all times if my information is to be shared. I give consent for the doctors and staff of this practice to collect and use my information as appropriate to ensure continuity of care.
- I wish to receive health awareness communication (as described above) and I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receipt of such health awareness communications.

Please tick YES or NO and sign below:

I have read, understand and agree to all the information on this form **YES** ☐ **NO** ☐

.....

Name (print) **Signature &**

Date ……/……/……..