Middle Camberwell
MEDICAL CENTRE

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Camberwell, Vic 3124
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NEW PATIENT REGISTRATION

NAME Mr Mrs Miss Ms

SURNAME ____________________

FIRST NAME: ____________________ MIDDLE NAME ____________________

ADDRESS: ____________________

SUBURB: ____________________ STATE: __________ POSTCODE: __________

PHONE: HOME: __________ WORK: __________ MOBILE: __________

EMAIL: ____________________

D.O.B: ____________________ Are we able to contact you on the above email? __________

NEXT OF KIN NAME: __________ PH: __________ RELATIONSHIP: __________

EMERGENCY CONTACT NAME: __________ PH: __________ RELATIONSHIP: __________

GENDER MALE: FEMALE: OTHER: __________ (Circle answer) ABORIGINAL / TORRES STRAIT ISLANDER (Circle answer) YES NO

MEDICARE NO. ____________________ REF __________

PENSION NO. ____________________ EXPIRY __________

HCC NO. ____________________ EXPIRY __________

VETERAN AFFAIRS NO. ____________________ EXPIRY __________

PRIVATE HEALTH INS. YES NO INSURER: ____________________

COUNTRY OF BIRTH ____________________

OCCUPATION ____________________

(TICK ANSWER)

WHERE DID YOU HEAR ABOUT US: NEWSPAPER INTERNET WALKING BY RELATIVE/FRIEND

MY HEALTH RECORD: Do you give permission for the doctor to upload your health summary to ehealth.gov.au

YES NO (If you are unsure please ask reception)

MEDICAL HISTORY

ALLERGIES ANY ALLERGIES YES NO

NAME OF DRUG ____________________ REACTION ____________________

NAME OF DRUG ____________________ REACTION ____________________

SMOKER YES NO Ex-Smoker NUMBER PER DAY __________

ALCOHOL YES NO Standard Drinks per day: __________

Please Turn Over

MEDICAL CONDITIONS **(PLEASE LIST THEM)**______________________________

FAMILY HISTORY OF MEDICAL CONDITIONS (e.g. Asthma)______________________________

CURRENT MEDICATIONS

NAMES	DOSE	TIMES PER DAY

YOUR PRIVACY AND MEDICAL INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management. All information is de-identified. If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all times your health information is treated with utmost confidentiality. I have read and understood the above information regarding my medical information.

PATIENT / GUARDIAN SIGNATURE: ____________________ **DATE:** ____________