eclipse MEDICAL

PATIENT REGISTRATION FORM

TITLE *Miss *Ms *Mrs *Mr *Dr *Mast *Other	
Surname:	
First Name:	Middle name:
Date of Birth:	
Do you Identify as being (please circle) *Aboriginal Origin *Torres Strait Islander *Australian *Other ……………………… Are you Registered for the CTG Co – Payment? Yes No	
Residential Address:	
Postal Address: (If different from above)	
Home Phone: Mobile: Work Phone: Do you consent to SMS messages for Recalls and Reminders on the mobile number provided? Yes/ No	
Email Address:	
Occupation:	
Medicare Card Number: Ref No.	Expiry Date:
Concession Card - Pension / Health Care (please circle) Card Number:	Expiry Date:
DVA Gold/White (Please circle) Card Number:	Expiry Date:

NEXT OF KIN/EMERGENCY CONTACT DETAILS:	
Mr Mrs Ms Miss Mast Dr Other (please circle)	
NAME:	CONTACT NUMBER:
RELATIONSHIP to patient:	

How did you hear about our Clinic?

☐ Health Engine ☐Website ☐Advertisement/Brochure ☐ Facebook ☐ Google Search

☐ Other: (Please specify) …………………………………………………………………………………………

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The following questions are at your discretion to answer.

CURRENT HISTORY:

Do you have any Allergies? If so, please state: ……………………………………………………………………………………………

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Please list any Regular Medications (and dosage) including over counter/vitamins/minerals/supplements:

Past Significant Medical History (illnesses or operations) please list:

Have any members of your family been diagnosed or suffered from the following:

☐ Heart Disease ☐ Stroke ☐ Kidney Problems ☐ Prostate Cancer ☐ Tumors or Cancer
☐ Diabetes Type 1/2 ☐ Eczema ☐ Depression/Anxiety ☐ Other Mental Illness
☐ High Cholesterol ☐ High Blood Pressure ☐ Bowel Problems/Polyps ☐ Epilepsy
☐ Asthma ☐ Other: ………

Social History:

Smoking History: ☐ Never Smoked ☐ Current non-smoker ☐ Smoker - Number per day………………
Do you drink alcohol: ☐ No ☐ Yes - Number of standard drinks per week ……………………………

Are your immunisations up to date? Yes No Don't know

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

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

By signing this form you are agreeing not to request these from the doctor.

We have many health professionals such as general practitioners, specialists and allied health professionals that request patient information. We only disclose those details necessary for you to receive appropriate healthcare from the health service concerned.

Eclipse Medical have a no show/cancellation policy*. By signing below, you agree to pay a fee of $75.00, non- rebatable from Medicare, if you fail to give 24 hour's notice unless it is an unforeseen emergency. We aim to give all patients the much needed treatment they require and can give cancellations to patients in need of emergency care.*

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

By signing below, you agree to the terms stated above.

Signature of patient or guardian: ____Date _____________