ECLIPSE MEDICAL

NEW PATIENT REGISTRATION FORM

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

Last Name:	**Given names:**		
Date of Birth: / /	**Gender:** ☐ Male	☐ Female	☐ Other

Street address:

Suburb: **Postcode:**

Home Phone: **Mobile Number:**

Email:

MEDICARE CARD NUMBER: __ __ __ __ __ __ __ __ __ __

Reference number (number on left side of your name): ____ Expiry date: / /

Do you have any ***Concession Cards****?*

☐ *Health Care Card?* ☐ *Pension Card?* ☐ *Commonwealth Seniors Card?*	**Entitlement number:**	**Expiry Date** / /
DVA Card? ☐ *White?* ☐ *Gold?*	**Entitlement number:**	**Expiry Date** / /

	Name:	**Relationship:**	**Phone number:**
Next of Kin			
Emergency Contact			

Patient's Occupation:

Marital status: *Single* ☐ *Defacto* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Other* ☐

The following information will assist us in the planning and provision of the best possible care.

Are you of Aboriginal or Torres Strait Islander origin?

☐ *No*
☐ *Yes, Aboriginal*
☐ *Yes, Torres Strait Islander*
☐ *Both, Aboriginal and Torres Strait Islander*

Ethnicity and/or Country of Birth - ____________________________________

Is English your first language: ☐Yes ☐No

If English is not your first language, do you require an interpreter?
☐ Yes ☐No

How would you like us to contact you?

☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Post

Can we send an SMS or leave a message on your message-bank regarding an appointment?

☐ Yes ☐ No

Can we put your name on a formal reminder system for preventative care? ☐ Yes ☐ No

Privacy statement:

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988) and Privacy Amendment (Enhancing Privacy Protection) Act 2012. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

☐ ***I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE***

Signature: ____________________________________ ***Date:*** / / /

PATIENT NAME: ____ **DOB:** ______/______/______

Your Medical History

Do you suffer from any medical problems? ☐ YES ☐ NO
If yes, please list them below with year of diagnosis:

____
____
____
____

Have you had any operations/surgery? ☐ YES ☐ NO
If yes, please list them below with year of procedure:

____
____
____
____

Please list down any current medications (prescription and non-prescription) that you are taking.

____
____
____
____

Do you have any allergies? ☐ YES ☐ NO
If yes, please list below (include type of reaction, if known):

____
____

Are you a smoker? ☐ YES ☐ NO ☐ EX-SMOKER

If yes, how many do you smoke _________/day.

When did you start smoking ______________ (Year commenced)

If you are an ex-smoker, when did you stop? _______ How many were you smoking ______/day.

How many days a week do you consume alcohol? _______ days/week

How much alcohol would you consume on each occasion? ________ SD

(Please enter appropriate number of standard drinks. 1 standard drink = 1 glass of wine OR 1 can/pot of beer OR 30mL of spirits)

Family History (Parents/Grandparents/Siblings)

Do any of your family members suffer from:

Cancer	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Any Genetic disorders	☐ YES	☐ NO

Signature: ____ Date: ____/___/____