Warrnambool Medical Clinic - Patient Registration Form

Warrnambool Medical Clinic takes its obligations under the Health Records Act 2001 (Vic) and the Privacy Amendment (Private Sector) Act 2000 (Commonwealth) seriously and will take all reasonable steps in order to comply and protect the privacy of the personal information that we hold.

Title: …… Mr ☐ / Mrs ☐ / Ms ☐ / Miss ☐

Family Name…………………………Given Name(s) .... Preferred...........................

Residential Address: ....

Postal Address (if different): ....

Email: .... Telephone: (H): ……………. (W): ……………. (Mob): ....

Gender: Male ☐ / Female ☐ / Other ☐ Preferred mode of contact (eg Mobile): ....

Date of Birth: ……. / ……. / ……. Occupation: ....

To assist us with Health Initiatives:

Do you identify as: Aboriginal – **Yes** ☐ **/ No** ☐ and/or Torres Strait Islander **Yes** ☐ **/ No** ☐

Other Cultural origin (please state): ………………………… Preferred Language Spoken: ....

Do you require the assistance of an interpreter? **– Yes** ☐ **/ No** ☐

Next of Kin Details:

Name: ....

Relationship:……………….. Ph: ....

Emergency Contact (if different):

Name: ....

Relationship: ………………… Ph: ....

Medicare Card No.:………………………………………… Ref. No.: …………………… Expiry Date: ……. / 20……

Veteran Affairs Card No.: …………………………… Veteran Affairs Card Type: Gold / White

Pension Card No.: …………………………………… Expiry Date: …… / ……. / 20……

Health Care Card No.: ……………………………… Expiry Date: …… / ……. / 20……

Allergies: Yes ☐ / No ☐ known Allergies

If Yes: Please list: ....

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Do you smoke:

Never ☐ / Current ☐ / ex-Smoker ☐

Current: Days per week? ………. Per Day? ....

ex-Smoker: Days per week? ………. Per Day? ....

Do you consume alcohol? Yes ☐ / Never ☐ / Not currently ☐

If Yes – Monthly or less ☐ , Weekly or less ☐ , 2 – 3 days per week ☐ , 4+ days per week ☐

Usual consumption: No. of standard drinks: 1 ☐ , 2 – 4 ☐ , 5 – 6 ☐ , over 7 ☐

Medication List (include herbs & over the counter medications); Please list dose if known:...

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Please read and sign your acknowledgement below

I hereby agree to pay all associated fees relating to my consultation.

I acknowledge that if an account is overdue, Warrnambool Medical Clinic reserves the right to refer the account to a collection agency.

I agree to meet all reasonable costs and commissions incurred in employing the said agency, to collect the overdue amount.

I agree:

To have any relevant Health Reminders sent by SMS or mail; e.g. Pap Smear / health check / diabetes / immunisations

To having my de-identified records viewed for general practice accreditation / research purpose / quality assurance

To receive my results electronically; e.g. SMS

To having my Health record shared with other health professionals to whom I may have been referred.

I have read and understood the above arrangements:

Patient Signature: ………………………………………………………………… **Date:** ....