Milton Village Medical

NEW PATIENT REGISTRATION FORM

Date:	

PATIENT INFORMATION

Title:	First Name:	Middle:	Surname:

Address:

State: Suburb: Postcode:

Date of Birth:	Medicare No.: Ref #: Expiry:	Email Address: ***Milton Village Medical will use this email address to communicate with you for persona health related matters.***
Mobile phone no.:	Home phone no.:	Work phone no.:
DVA Card No.: Expiry Date:	Pension/Healthcare Card No.: Expiry Date:	Private Health Fund: Membership No.:
Ethnicity:	Are you of Aboriginal or Torres Strait Islander Origin?: No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal/Torres Strait Islander ☐	

Allergies:

How did you hear about us:

If under the age of 18 please list parental/Guardian details below:

Parent/Guardian #1: Relationship to child:	Contact No.:
Parent/Guardian #2: Relationship to child:	Contact No.:

IN CASE OF EMERGENCY

Next of Kin:	Relationship to patient:	Home phone no.:	Mobile phone no.:
Emergency Contact:	Relationship to patient:	Home phone no.:	Mobile phone no.:

PRIVACY POLICY

In accordance with the Privacy Act (1998), all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act. We use the information you provide to manage your health care. In order for us to assist you, we must have all current contact info. It is the responsibility of the patient to maintain the accuracy of your information by advising the practice of changes of address, phone number, etc. Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. pathology, radiology, hospital, or specialists). If you have any questions regarding the management of your personal health information or need to arrange to access your records, please ask the staff or your Doctor, as appropriate.

The above information is true to the best of my knowledge. I understand and consent to the above listed Privacy Policy. I also understand that I am financially responsible for any balance incurred. ***I authorize the practice to contact me via any of the above details I have provided regarding any relevant health matters or reminders.***

Patient signature or Parent/Guardian signature Date

IMMUNISATION HISTORY

Have you had the following, please circle yes or no and provide the date given:

Tetanus Booster	Yes / No	Date:
Hepatitis B	Yes / No	Date:
Hepatitis A	Yes / No	Date:
Influenza	Yes / No	Date:
Pneumococcal	Yes / No	Date:
Polio	Yes / No	Date:

MEDICAL HISTORY

Do you have a history of the following, please circle yes or no and provide further information if necessary:

Operations	Yes / No	Please list:
Asthma	Yes / No	Details:
High Blood Pressure	Yes / No	Details:
Chronic Illness	Yes / No	Details:
Other	Yes / No	Details:

FAMILY HISTORY

Have any members of your family had the following:

Diabetes	Yes / No	Details:
Asthma	Yes / No	Details:
Cancer	Yes / No	Details:
Heart Disease or stroke	Yes / No	Details:
Mental Illness	Yes / No	Details:
Other	Yes / No	Details:

SOCIAL HISTORY

Tobacco	Yes / No	_____ day or week
Alcohol	Yes / No	_____ day or week
Drug use	Yes / No	Type and frequency?:
Height (cm):	Weight (kg):	
In the last 12 months, have you had the following checked/completed?		
Blood pressure	Yes / No	Date:
Cholesterol	Yes / No	Date:
Skin Check	Yes / No	Date:
Screening Test for Bowel Cancer	Yes / No	Date:
Cervical Screening Test (women)	Yes / No	Date:
Breast Check/Mammogram (women)	Yes / No	Date:
Prostate Check (men)	Yes / No	Date: