Mount WAVERLEY Clinic

Online Booking Available
www.mtwaverleyclinic.com.au

PATIENT REGISTRATION FORM

We would like to get to know you and help you to live a healthy life. To do this, we need to learn more about your health and the best ways to communicate. The more that you can tell us, the more that we can help. Your information will be treated in strict confidence.

CONTACT DETAILS

Title: Given names: Surname:

Preferred Name: DOB: Gender: M ☐ F ☐

Address:

Contact numbers: Home Work Mobile

Email: Occupation:

Medicare No: Reference No: Expiry Date:

Vet Affairs No: Expiry Date: Gold Card: Yes ☐ No ☐

Pension/Health Care Card No: Expiry Date:

OTHER CONTACT DETAILS

Emergency contact: Relationship to patient:

Contact numbers: Home Work Mobile

Next of kin: Relationship to patient:

Contact numbers: Home Work Mobile

CULTURAL DETAILS

Are you Aboriginal or Torres Strait Islander? No ☐ Yes Aboriginal ☐ Yes Torres Strait Islander ☐ Yes Both ☐

Cultural background: Country of birth:

Language spoken at home: Interpreter required: Yes ☐ No ☐

HOW DID YOU FIND OUT ABOUT US?

Word of Mouth ☐ Website/Google ☐ Signage ☐ Social Media ☐ Waverley Blues ☐ Other:

CONSENT/PRIVACY

We take an active approach to your health and use different ways to communicate with you for various reasons. Do you give us permission to:

- record your health information for medical and health related services or billing/administration? Yes ☐ No ☐
- disclose your health information to other health care providers involved in your treatment? Yes ☐ No ☐
- contact you or send you SMS reminders for upcoming appointments or as part of our follow-up system? Yes ☐ No ☐
- send you emails or letters about upcoming health related opportunities at our practice? Yes ☐ No ☐

If answered 'No' to any of these questions, please provide more information below or speak to our friendly team:

I (Patient / Guardian Name) agree that this information is accurate and true to the best of my understanding and that there is no other information that would influence the medical treatment or advice to be provided.Any limitations that I place on the handling of my personal information, I undertake to set out in writing.

Signature Date Patient ☐ Guardian ☐

Please complete page 2.

Name

MEDICAL HISTORY

Do you have any allergies or sensitivities including to medicines or dressings?

No ☑ Yes ☑ (please list)

Are you currently using any prescribed or over the counter medications or vitamins and minerals?

No ☑ Yes ☑ (please list)

Do you have or have you ever had a history of:

Heart problems	No ☐ Yes ☐	Serious trauma, major operations	No ☐ Yes ☐
High blood pressure	No ☐ Yes ☐	Diabetes	No ☐ Yes ☐
Asthma, respiratory problems	No ☐ Yes ☐	Abnormal pap smear	No ☐ Yes ☐
Ear or hearing problems	No ☐ Yes ☐	Mental Health	No ☐ Yes ☐
Eye or vision problems	No ☐ Yes ☐	Operations	No ☐ Yes ☐

Chronic Illness

PREVENTATIVE HEALTH

When was your last check for the following (approximately):

Cholesterol	Date	Not sure ☐	Never ☐
Blood pressure	Date	Not sure ☐	Never ☐
Fasting sugar	Date	Not sure ☐	Never ☐
HIV	Date	Not sure ☐	Never ☐

Patients 45-49: Have you had a recent health assessment, including blood tests No ☐ Yes ☐

MALE

Prostate	Date	Not sure ☐	Never ☐

FEMALE

Pap Smear	Date	Not sure ☐	Never ☐
Breast Check	Date	Not sure ☐	Never ☐
Mammogram	Date	Not sure ☐	Never ☐

IMMUNISATION HISTORY

If this record is for a child, please also provide immunisation record book at your first appointment.

Tetanus	No ☐ Yes ☐ Not sure ☐	Measles	No ☐ Yes ☐ Not sure ☐
Chicken pox	No ☐ Yes ☐ Not sure ☐	Polio	No ☐ Yes ☐ Not sure ☐
Hepatitis A	No ☐ Yes ☐ Not sure ☐	Hepatitis B	No ☐ Yes ☐ Not sure ☐
Rubella	No ☐ Yes ☐ Not sure ☐	Meningococcal	No ☐ Yes ☐ Not sure ☐
Influenza	No ☐ Yes ☐ Not sure ☐	Pneumococcal	No ☐ Yes ☐ Not sure ☐

FAMILY HISTORY

Have any of your direct relatives ever had:

Diabetes	No ☐ Yes ☐	Psychiatric Illness	No ☐ Yes ☐
Heart Disease	No ☐ Yes ☐	Other:	
Cancer	No ☐ Yes ☐		

SOCIAL HISTORY

Do you exercise	No ☐ Yes ☐	how many times per week?	Duration of exercise?
Do you smoke	No ☐ Yes ☐	how often?	Smoking for how many years?
		if ceased, approx date	
Do you drink alcohol?	No ☐ Yes ☐	how many days per week?	Number per occasion?
Do you use recreational drugs?	No ☐ Yes ☐	how often?	what type?

LIVING ARRANGEMENTS (optional)

Live Alone ☐ With Spouse/De Facto ☐ Family ☐ Parents ☐ Friend ☐

Religion:

We comply with the National Privacy Principles in collection, storage and transfer of your information.
Our privacy policy is available online or by asking one of our friendly receptionists.

Mount Waverley Clinic
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