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AND TRAVEL MEDICINE

Knoxfield and Colchester Medical Centres
310 Colchester Road, North Bayswater Vic 3153
34 Riddell Road, Wantirna South Vic 3152
www.yourfamilydoctor.com.au

New patient registration form: Please present completed forms to reception

Contact Information		
Family name:		
Given name:	Preferred name:	
Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Date of birth:	
Gender: ☐ Male ☐ Female ☐ Indeterminate ☐ Non-specific		
Home Address:		
Postal Address: ☐ Same as above		
Home Phone:	Consent to Home phone messages	☐ No ☐ Yes
Mobile Phone:	Consent to SMS messages	☐ No ☐ Yes
Employer:	Work Phone:	
Email Address:		
Consent to email communication: ☐ Yes ☐ No		

Health care Identifiers		
Medicare Card No:	Ref:	Expiry:
DVA Card number:	Colour: ☐ Gold ☐ Orange ☐ White	
Pension/Health care card number:	Expiry:	

Cultural Identity	
To assist with health initiatives - are you of Aboriginal and /or Torres Strait islander descent?	
☐ Yes- Aboriginal ☐ Yes- Torres Strait Islander ☐ Yes- Both Aboriginal & Torres Strait Islander ☐ Neither	
Country of Birth:	Ethnic Background:
Languages spoken:	
Do you require an interpreter service? ☐ Yes ☐ No	

Patient MyHealthRecord Status
Do you have MHR (My health record)? ☐ Yes ☐ No ☐ Unsure

Account payer if Patient under 12 years of age / Next of Kin / POA	
Name	Relationship to patient
Gender:	Date of Birth:
Contact Number:	Email:

Next of Kin	
Name:	Relationship to Patient:
Email:	Home phone:
Mobile Phone:	Work phone:
Other emergency contact:	Email:
Name:	Contact Number:

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Information & Privacy Patient Consent:

Both Knoxfield and Colchester medical centres collect information from you for the purpose of providing quality health care. We require you to provide us with your personal details and a medical history so that we may properly assess, diagnose, treat and be pro-active in your health care needs.

We may use the information you provide, in the following ways

- Administrative purposes
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclosure to other doctors, medical students, allied health workers and nurses who may work within both practice settings and Accreditation surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.
- Providing our patients with preventive care and early case detection reminders (e.g. immunisations, annual health checks, skin checks and pap smears)

By signing this document below, I agree to the following:

• I have read the information above and understand the reasons why my information may be collected. I am also aware that both clinics have a privacy policy on handling sensitive patient information.
• I understand that I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of care and treatment given to me.
• I am aware of my right to access the information collected about me, except in some circumstances where access may legitimately be withheld. I understand I will be given an explanation in these circumstances.
• I understand that if my information is to be used for any other purpose other than set out above, my further consent must be obtained.
• By completing and providing a signature below, I consent to the handling of my information by both Knoxfield Medical clinic & Colchester Medical clinic for the purposes set out above.

Patient name

Your name (if not patient) Relationship to the patient

Signature Date

Medical History Information:

Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes _____

Do you Smoke?

☐ No ☐ Yes _____ Per Day

Do you Drink Alcohol?

☐ No ☐ Yes _____ Per Day

Do you or have you had a history of the following? (please elaborate)

☐ Operations _____ ☐ Asthma _____

☐ Diabetes _____ ☐ Hypertension _____

☐ Chronic Illness _____ ☐ Other _____

Immunisations

Have you had the following immunisations? (List date where appropriate & if known)

Tetanus Booster	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis B	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Hepatitis A	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Influenza	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Pneumococcal	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know
Measles/Mumps/Rubella	☐ Yes Date: ____/____/____	☐ No	☐ Don't Know

Children's Immunisations

If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

_____ _____

_____ _____

_____ _____

Is there anything else you would like your doctor to know?

_____

_____

Past Medical Records/History

Would you like to transfer your past medical records/history to Knoxfield/Colchester Med Centre?

☐ No ☐ Yes, from: _____

Signed: _____ Date: _____/_____/___