VITALIA HEALTHCARE
WE CARE

Contact information

Family Name			
Given Name		Preferred Name	
Title		Gender	☐ Male ☐ Female ☐ Unspecified
Date of Birth			
Home address			
Postal Address ☐ Same as above			
Home Phone		Consent to home phone messages	☐ No ☐ Yes
Mobile Phone		Consent to SMS appointment reminders	☐ No ☐ Yes
Work Phone			
Email Address		Consent to email communication	☐ No ☐ Yes

Healthcare Identifiers

Medicare Number	IRN	Exp /
DVA File Number		Exp / /
Concession (pension/healthcare) card number		Exp / /
Workers Comp / MVIT Claim Number		

Cultural Identity

☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal & Torres Strait Islander ☐ No

Country of Birth		Ethnic Background	
Languages Spoken			

Do you require an interpreter service? ☐ Yes ☐ No

Patient Status

Are you registered with My Health Record? ☐ Yes ☐ No ☐ Unsure

Patient Under 16 years of age – Account Payer (Leave blank if not applicable)

Name		Relationship topatient	
Gender			
Date of Birth			

Next of Kin

Relationship to patient:

Name		Home Phone	
Mobile Phone		Work Phone	

Emergency Contact

Relationship to patient:

Name		Home Phone	
Mobile Phone		Work Phone	

BE SURE TO FOLLOW US ON FACEBOOK

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NEW PATIENT REGISTRATION FORM
Patient Consent

This medical practice collects information from you for the primary purpose of providing quality health care.

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

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Workers Compensation, Motor Vehicle, DVA, 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, allied health workers and nurses who may work in the practice, including Locums 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.

By signing this document below, I agree to the following

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health 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 might 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 will be obtained.
- By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.
- I consent or decline as indicated to receive an SMS message regarding future appointments
- I consent or decline as indicated to messages being left on telephone message service

_____
Patient Name

_____ | _____
Your name (if you are not the patient) | Relationship to the patient

_____
Signature

Date

How did you hear about the clinic? (Please tick)

☐ Website ☐ Drive/walk past ☐ Pharmacy ☐ Leaflets/Flyers ☐ Facebook
☐ Word of mouth ☐ Google ☐ Other: _____

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PATIENT MEDICAL HISTORY

First Name: _____ **Surname:** _____

DOB: _____

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

Yes (If yes please list below) ☐ No ☐

Allergy: _____

Your Health History – PLEASE INCLUDE AS MUCH DETAIL AS POSSIBLE ON *ALL* OPERATIONS, PROCEDURES AND MEDICAL CONDITIONS SINCE YOU WERE BORN. *IT IS VERY IMPORTANT THAT WE KNOW ALL YOUR MEDICAL HISTORY.*

_____

_____

_____

_____

_____

_____

Immunisations - Have you had the following immunisations? (Please circle)

Tetanus booster	Date_____	Yes	Don't Know	Haven't had one
Hepatitis B	Date_____	Yes	Don't Know	Haven't had one
Hepatitis A	Date_____	Yes	Don't Know	Haven't had one
Influenza	Date_____	Yes	Don't Know	Haven't had one
Pneumococcal	Date_____	Yes	Don't Know	Haven't had one
Polio	Date_____	Yes	Don't Know	Haven't had one

Children's Immunisations - If completing this form for a child, are their immunisations up to date?

Yes ☐ No ☐

Current Medications (including over the counter medications, vitamins and minerals)

_____

_____

_____

_____

Family History

Has any members of your family had (please circle):

Diabetes	**Yes**	**No**
Asthma	**Yes**	**No**
Heart Disease	**Yes**	**No**
Mental illness	**Yes**	**No**
Cancer	**Yes**	**No**
Hypertension	**Yes**	**No**

Other: _____

Social History

Tobacco:_____day / week or Ceased Smoking – date___/____/___

Alcohol: _____ day / week / month (circle the one applicable)

Drug use: _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

Blood Pressure:

When was the last time your blood pressure was taken? ___/____/___ Not Sure

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Females: When did you last have? (Please List)

Pap smear - Date_____ Not sure ☐ Never ☐

Mammogram - Date_____ Not sure ☐ Never ☐

Obstetric History

Please list details of previous pregnancies_____

_____

_____

Males: When did you last have?

An overall check up Date _____ Not sure ☐ Never ☐

Patients Signature or Parent / Guardian (if child is a minor)

_____ **Date** ____/____/____