ARARAT MEDICAL CENTRE

CONFIDENTIAL PATIENT REGISTRATION FORM

Welcome! Please fill in the form and ask for assistance if required.

Patient Details

Family Name: ……………………………………………………Sex: M / F Title:……………………………

Given Names:……………………………………………………………Preferred Name…………………………………

Marital status (please circle) Single Married De Facto Separated Divorced Widowed

Other………………………. No. of Children ……………………….

Address:……………………………………………………………………………………… Post Code……………………

Date of Birth: / / Medicare No ☐☐☐☐ ☐☐☐☐☐ ☐

Expiry date on Medicare card / Your Medicare reference no…………………………

Occupation…………………………………. Place of Employment:…………………………………………………

Telephone: (Home)…………………………………… (Work)………………………………………………………

(Mobile)………………………………… Email Address:…………………………………………………………

Drivers Licence Number ☐☐☐☐ ☐☐☐☐☐ Expiry Date __ __ / __ __

Cultural Background: (please circle) Aboriginal Torres Strait Islander Other ………………………….

Do you need an interpreter to assist with your visit to the doctor? (Please circle) Yes No

Emergency Contact

Name……………………………………….. Relationship to you…………………………………DOB ………….

Immunisations (please tick relevant boxes) Date Given

☐ Tetanus Date Given ……………………………

☐ Fluvax Date Given …………………………….

☐ Childhood vaccines up to date Date Given …………………………….

☐ Other (please specify) ………………………………………………………………. Date Given ……………..

Patient Health History

Please list your current and regular medications including vitamins and herbal medicines

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Please list any allergies or intolerances to medications

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Please list any medical history and past surgery / operations and previous illnesses / injuries

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Smoking history

☐ Never ☐ Former smoker: quit / /

☐ Current Smoker: / day

Number of years smoking ....

Alcohol

☐ Non Drinker ☐ Occasional

☐ Moderate ☐ Heavy

Exercise

Do you regularly exercise (please circle) Yes No

Please detail exercise undertaken and regularity

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SMS Appointment Reminder

The Ararat Medical Centre offers patients a free SMS appointment reminder service. We will use your mobile number to provide you with an appointment reminder service by SMS and we may also communicate with you by SMS from time to time for other appointment, billing and health issues.

Would you like this service (Please circle) Yes No

You may opt out of this service at any time by putting your request in writing including your mobile number to the Practice Manager.

Clinical History

Please indicate whether you have any of the following conditions

☐ High / Low BP	☐ Migraines / Headaches	☐ Fluid Retention
☐ Heart Problems	☐ Fainting / Blackouts	☐ Problems with any organs
☐ Asthma / chest problems	☐ Vertigo	☐ Reproductive problems
☐ Respiratory illness	☐ Kidney Disease	☐ Skin Condition
☐ Tuberculosis	☐ Sciatica/ lumbago/back pain	☐ Can't get pregnant
☐ Thrombosis/circulatory condition	☐ Cancer What type?	☐ Pregnant How many weeks?
☐ Haemophilia / bruising	☐ Claustrophobia	☐ Diabetes
☐ Stroke	☐ Joint pain / discomfort	☐ Epilepsy
☐ Stress	☐ Varicose Veins	☐ Thyroid Disease
☐ Allergies	☐ HIV Positive / AIDS	

Do you have any other diseases or conditions that you are aware of? (please circle) Yes No

If yes, please list:

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Family Health History

Please tick if any of your family members have had any of the following. Please additionally specify which family member (e.g. Mother, father, sibling, grandparent, other)

☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ Asthma	☐ Parkinson's	☐ Obesity
☐ Alzheimer's	☐ Epilepsy	☐ High Blood Pressure
☐ Cancer (please specify type)		

ACCOUNT DETAILS

Do you have Private Health Insurance? Yes / No (If yes, present your card) ………………………………………………

Are you on a Pension/Veterans Affairs? Yes / No (If yes, present your card) ………………………………………………

Do you have a Health Care Card? Yes / No (If yes, present your card) ………………………………………………

☐ T.A.C. Claim No:……………………………………

☐ Workcover Employer:…………………………………… Employer's Address:……………………………………….

Claim No:……………………….... Contact Name:……………………………… Telephone No:…………………………….

CONTACT FOR EMERGENCY ENQUIRIES

Surname Given Names Relationship to You Contact Phone

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It is the policy of the practice that full payment for your consultation is due on the day of service. Payment can be made via Cash, Cheque, Credit Card, Eftpos or Electronic Transfer.

Any account not settled at the time of service will be treated as an overdue account, and followed up accordingly.

A missed appointment fee will be charged if due notice is not given, or if there is a history of repeated failure which is non-refundable by Medicare.

The personal health information that you provide during your consultation and subsequent treatment will be collected for the purpose of providing high quality health care. The clinic's policy is to protect your privacy and this information in only disclosed to other members of your treating team where necessary. It will, however, be disclosed to other organizations where required by law, if necessary, for debt recovery purposes. You may gain access to information about you held by this clinic by contacting us in writing.

I have read, understood and agree to the above and I consent to information being released from my medical records, and by attending the AMC, I am legally responsible for all charges incurred on my account, including any costs associated with collecting the total account balance as indicated above.

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