# Patient Registration

Surname _____ First name _____ Mr / Mrs / Miss / Ms

Preferred name_____ Sex F / M

Address _____Suburb_____Postcode_____

Date of Birth _____

Phone (H) _____ (W) _____ (M)_____

Consent to contact (reminders/recalls for flu & blood tests, sms, healthcare information etc) Yes / No

Email _____

If patient is a child, Parent / Guardian's - Surname _____ First name_____

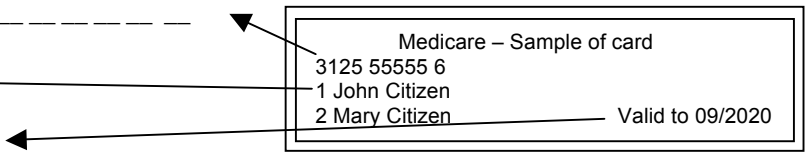
DOB_____ Relationship to child_____

Payment is expected on the day of service, person responsible for the account _____

Medicare Card Number __ __ __ __ __ __ __ __ __ __

Reference Number ____

Valid To _____




DVA Number _____ Expiry Date _____

HCC/Pension Number _____ Expiry Date _____ Full / Part pension

Are you of Aboriginal or Torres Strait Islander descent? Yes / No

Next of kin _____Ph(H)_____(M)_____Relationship_____

Emergency Contact _____Ph(H)_____(M)_____Relationship_____

**How did you hear about Wheelers Hill Clinic**

- ☐ Family attend clinic
- ☐ Personal recommendation by _____
- ☐ Saw the sign
- ☐ Employer
- ☐ Yellow Pages
- ☐ Web site - whclinic.com.au
- ☐ Internet - which site?_____
- ☐ HealthEngine /online booking
- ☐ Aged Care Facility (name) _____

**Please complete back of form**

# Medical History

**Please provide approximate date/s**

□ High Blood Pressure _____

□ Heart Disease _____

□ Stroke _____

□ Diabetes _____

□ High Cholesterol _____

□ Cancer If so, where_____

□ Arthritis _____

□ Asthma _____

□ Respiratory/Lung disease _____

□ Urinary/Kidney problems_____

□ Overweight/Obesity_____

□ Neurological problem _____

□ Migraine_____

□ Epilepsy_____

□ Broken Bones _____

□ Osteoporosis_____

□ Bowel problems _____

□ Prostate problems _____

□ Dermatitis/Eczema _____

□ Gallstones_____

□ Digestive problems, ulcers_____

□ Gout_____

□ Breast problems _____

□ Testicular problems_____

□ Anxiety / Psychological disorders_____

□ Infectious Disease _____

□ Smoke_____

□ Gynaecological problems_____

□ Other relevant medical history _____

□ Direct family history of illness_____

□ History of operations & approx. year/s? _____

_____

□ Do you have any allergies? _____

□ Any other medical history the doctor should be made aware of?_____

_____

**Privacy Statement –** Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised personnel. The clinic adheres to a strict Privacy Policy, by signing below you are consenting to the terms and conditions as set out in our 'Health Information Collection and Use' form (both are available from reception). You are also accepting responsibility for your account which is payable on the day. Late payment may incur an administration fee.

Signed _____ Date _____