CAPEL MEDICAL CLINIC

New Patient Registration Form

Filling in this form: Please print in BLOCK LETTERS Mark boxes ☐ with ✓ or ✗ *Return the completed form to the front desk*

Surname: | First Name: | Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Dr ☐

Middle Name *(if any)*:

Preferred Name:

Have you been known previously under another name?

No ☐ Yes ☐ *(Details)*: *please specify*

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Gender: Male ☐ Female ☐ Other ☐ (*please specify*)

Marital Status: Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed ☐

Residential Address — Street Address: | State:

Suburb: | Postcode: ☐☐☐☐

Postal Address: *(if different to the Residential Address above)*

Phone: Home: | Mobile:

Email: @

Occupation: | Employer *(if applicable)*

Medicare Card Number ☐☐☐☐☐☐☐☐☐☐ Ref No ☐ Expiry Date: ☐☐ / ☐☐☐☐

Concession Card Type *(if applicable)* ☐ Pension ☐ Health Care Card | Concession Card Number ☐☐☐ ☐☐☐ ☐☐☐ ☐ | Expiry Date: ☐☐ / ☐☐ / ☐☐☐☐

DVA Card *(if applicable)* DVA Card Type: Gold ☐ White ☐ | DVA Number ☐☐☐☐☐☐☐☐ | Expiry Date: ☐☐ / ☐☐☐☐

Next of Kin *(who would be the best contact person in an emergency?)*

Name: | Relationship to You: | Mobile: | Home Phone:

Email: @

Cultural Background (*knowing your cultural background can help us provide healthcare that meets your individual needs)*

Do you identify yourself as: Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Neither ☐

Is English your first language? Yes ☐ No ☐ | *If No, specify your language:* Do you require an interpreter? *YES* ☐ *NO* ☐

Smoking Status: ☐ Never smoked ☐ Current smoker ☐ Ex-smoker (Year Quit:) ☐ Not Applicable

Alcohol intake: ☐ I do not drink ☐ I drink ( ) drinks per week (in average) ☐ Not Applicable

Allergies: *(Drugs, food etc)*

Guardian Contact Details (*Must be completed if a patient is under 16 years of age)*

Name: | Relationship to patient:

Phone: Mobile: | Home:

Email: @

Postal Address: Street Address: | Suburb:

State: | Postcode: ☐☐☐☐

Privacy Agreement & Patient Consent

Capel Medical Clinic (CMC) is committed to protecting your privacy under the Privacy Act (1988). We will collect, store, use and disclose your information necessary to provide quality medical care to you. Such necessary information may include your personal details, identification and contact details, full medical history, family and employment history, billing/account details, Medicare and private health fund details. With your consent, CMC, its staff and authorised representatives may use and disclose your information for purposes such as billing and administrative purposes including compliance with Medicare Australia, referral to other care providers, referral for medical tests and in the reports and results returned to us following these referrals, inclusion in the State and National health registers and reminder systems, and to contact you via SMS, phone or mail for the purpose of Recalls and Reminders. You are entitled to access your health records at any time (conditions apply). To access our full Privacy Policy please ask our staff or visit our website (www.capelmedicalclinic.com.au). By signing this form, you confirm you have read and understood this Privacy Agreement, and you consent for Capel Medical Clinic to collect, store, use and disclose your information as outlined in our Privacy Policy.

Print Name:

Signed by Patient *(or Guardian)*: Date: *dd / mm / yy*