New Patient Registration Form

CAPEL MEDICAL CLINIC

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)*:	Have you been known previously under another name?	
Preferred 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:	State:
	Suburb:	Postcode:
Postal Address:	*(if different to the Residential Address above)*	
Phone: Home:	Mobile:	
Email: @		
Occupation:	Employer *(if applicable)*	

Medicare Card No		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 No:		Expiry Date:	/ /

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

Name:	Relationship to You:	Mobile:
Email: @		Home Phone:

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

Do you identify yourself as? Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous Australian ☐ Other ☐		
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 day (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: Suburb: State: Postcode:	

Privacy Agreement & Patient Consent

Capel Medical Clinic (CMC) is committed to protecting your privacy under the Privacy Act (1988). With your permission, we will collect, store, use and disclose your information necessary to provide quality medical care to you. Such information may include your 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 and affiliates may use and disclose your information for purposes such as account management, compliance with Medicare Australia and referral to other health care providers. CMC may be required to use your information to update the State and National health registers and reminder systems. CMC may contact you via SMS or phone to notify you of Appointments, Recalls and Reminders. CMC requires that sensitive information (e.g. test results) only be communicated face-to-face by a medical practitioner or qualified health professional. 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 CMC to collect, store, and use your information as outlined in our Privacy Policy.

Print Name:	
Signed by Patient *(or Guardian)*:	Date: / /