BRIGHTON MEDICAL CLINIC

General Family, Womens and Travel Clinic.

24-26 Carpenter Street, Brighton, 3186
Telephone: 9592 0222 | Fax: 9592 6095
Mon – Fri: 8am – 6pm | Sat: 9am – 12pm
Closed Sunday and all public holidays

REGISTRATION FORM

Patient Family Name:	Title:
Patient Given Name:	Preferred Name:
Date of Birth:	
Street Address:	
Suburb and Post Code:	
Postal Address: (if different from above)	
Home Phone:	Preferred contact: Yes / No
Mobile Phone:	Preferred contact: Yes / No
Medicare Number _ _ _ _ _ _ _ _ _ _ _ Ref No: _	Expiry Date:
DVA Gold / White: (Please circle)	Expiry Date:
Pension Number:	Expiry Date:
Health Care Card Number:	Expiry Date:
Private Health Cover:	
Person Responsible for account Name: Date of Birth (for Medicare Claiming):	
Next of Kin (Name, Relationship and Phone number)	
Emergency Contact (Name, Relationship and Phone number of the person we can contact if needed)	

To assist with health initiatives:
Are you of Aboriginal or Torres Strait Islander origin? YES ☐ NO ☐
Other Cultural Background? YES ☐ NO ☐

Please identify: ____________________

Do you consent to receiving via SMS:
"health and appointment"reminders? YES ☐ NO ☐

Do you consent to receiving "test result" messages from your doctor via SMS? YES ☐ NO ☐

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Brighton Medical Clinic takes your privacy seriously. Privacy protection and confidentiality of health information is essential for quality health care and we are committed to protecting the privacy and confidentiality of the information we handle about you.

(To be read in conjunction with the Practice Privacy Policy)

I, ______________________________ have read and understand the information contained in the Brighton Medical Clinic Practice Privacy Policy, including:

- The types of personal information collected by the Practice, the reasons why it is necessary to collect it and the circumstances in which my personal information may be used or disclosed.
- That I may request access to my personal information, which may be granted in accordance with the practice's Access to Personal Information Policy. I will be provided with a written reason if access is denied.
- That I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied.
- That my personal information will not be used for direct marketing or disclosed to overseas recipients.
- That I am not obliged to provide the Practice with my personal information, but withholding information may limit the Practice's ability to provide me with full service.
- That I have the right to lodge a complaint about the handling of my personal information if I am dissatisfied, which will be dealt with in accordance with the Practice's complaint handling procedure.

Patient Name: (Please Print) ______________________________

Signature: ______________________________ Date ______________________________

(On behalf of patient) Name: ______________________________

Relationship to patient: ______________________________

Signature: ______________________________

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PRIVATE & CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY

We are committed to providing our patients with the best care, and to do this it is essential that your medical records are up to date and accurate.

PLEASE ASSIST US BY COMPLETING THE FOLLOWING INFORMATION YOU ARE COMFORTABLE WITH AND HANDING IT DIRECTLY TO YOUR DOCTOR

Name ______________________ Title ________ Age ________

Marital Status ____________ Occupation ____________ Your mobile no. is ____________

Do you consent to receiving pathology results via SMS mobile message? YES ☐ NO ☐

Height ____________ Weight ____________

Do you have any drug or other allergies that you are aware of?

Yes ☐ No ☐

If yes, please list the allergy and reaction ____________

Do You Smoke?

Yes ☐ No ☐ If yes, how many per day ____________

If you previously smoked and have now quit, when did this occur? ____________

Do you drink Alcohol?

Yes ☐ No ☐ If yes, how many standard drinks per day? ____________

Do you have a history of any serious illness or disease?

Yes ☐ No ☐

Please list and include operations: ____________

Please list your Current Regular Medications: ____________

Do you have a family history of any serious illness or disease?

Yes ☐ No ☐

(Asthma, Bowel Cancer, Heart Disease, Breast Cancer, Prostate Cancer, Diabetes)

If so, name the illness and family relationship to you ____________

List of Immunisations and approx date/year (if known) ____________

Females: When did you last have?

Pap smear ____________

Breast Check ____________

Skin Check ____________

Males: When did you last have?

An overall check up ____________

Skin Check ____________