Moonee Ponds Super Clinic

45 Hall Street
Moonee Ponds, VIC 3039
Ph: 99764200 Fax: 99764202
E-mail: admin@mpsuperclinic.com.au

New Patient Registration Form

We would like to get to know you and help you to live a healthy life. To do this, we need to learn more about your health and the best ways to communicate. The more that you can tell us, the more that we can help. Your information will be treated in strict confidence.

Contact Details

Title ..... Given Name: .....

Family Name: ..... Preferred Name: .....

Date of Birth: ...../...../..... Gender: Male/Female/Others (please specify) .....

Street Address: .....

.....

Suburb: ..... Postcode: ..... Postal Address: (if different):

.....

Email: .....

Mobile Phone: ..... Home: ..... Work: .....

Insurance Information

Medicare No..... Ref No..... Expiry Date: ...../...../.....

Eligible for concession: Yes ◯ No ◯

Card type: ..... Card No: ..... Expiry Date: ...../...../.....

Personal Details

Do you identify as: Aboriginal ◯ Torres Strait Islander ◯ Both Aboriginal and Torres Strait Islander ◯ Neither ◯

Country of Birth: ..... Ethnicity: .....

Religion: ..... Occupation: ..... Marital status: .....

Next of Kin: ..... Phone: ..... Relationship: .....

Emergency Contact: ..... Phone: ..... Relationship: .....

Medical History

Do you have any **allergies** to medicines or are you **sensitive** to any dressings?

No ◯ Yes ◯ (please list): .....

Are you currently using any prescribed or over the counter medications or vitamins and minerals?

No ◯ Yes ◯ (please list): .....

.....

Do you have, or have you ever had a history of:

◯ Stroke	◯ Fractures	◯ High Cholesterol	◯ Glaucoma	◯ Back Pain
◯ Epilepsy	◯ High Blood Pressure	◯ Kidney Disease	◯ Liver Disease	◯ Bronchitis
◯ Asthma	◯ Anxiety/Depression	◯ Diabetes	◯ Hep C	◯ Hep B

Any Other? .....

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Family History

Mother:

◯ Stroke	◯ Fractures	◯ High Cholesterol	◯ Glaucoma	◯ Back Pain
◯ Epilepsy	◯ High Blood Pressure	◯ Kidney Disease	◯ Liver Disease	◯ Bronchitis
◯ Asthma	◯ Anxiety/Depression	◯ Diabetes	◯ Hep C	◯ Hep B

Any Other? .....

Father:

◯ Stroke	◯ Fractures	◯ High Cholesterol	◯ Glaucoma	◯ Back Pain
◯ Epilepsy	◯ High Blood Pressure	◯ Kidney Disease	◯ Liver Disease	◯ Bronchitis
◯ Asthma	◯ Anxiety/Depression	◯ Diabetes	◯ Hep C	◯ Hep B

Any Other? .....

Social History

Do you exercise? ◯ No. ◯ Yes, how many times per week? .....
Duration of exercise per day? .....

Do you smoke? ◯ No ◯ Yes, year commenced? .....
How many per day? .....

Do you drink? ◯ No ◯ Yes, how many days per week? .....
Number of drinks per day? .....

Do you use recreational drugs? ◯ No ◯ Yes, how often? .....
What type? .....

Consent

Our practice uses a recall and reminder system if you do not wish to be contacted via SMS or partake in this service please let your receptionist know.

I understand that Moonee Ponds Super Clinic complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Moonee Ponds Super Clinic collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Moonee Ponds Super Clinic to use and disclose my personal information (except when legal obligations must be met).

If you miss an appointment and fail to notify the practice 3 hours in advance a $50 fee will be charge for each time you do not attend to your appointment. Please, call at least 3 hours prior to your scheduled time if you are unable to keep your appointment.

I Patient / Guardian Name) ....., agree that this information is accurate and true to the best of my understanding and that I am responsible for cancelling appointments at least 3 hours prior to the appointment.

Signature ..... Date ...../...../..... ◯ Patient ◯ Guardian