PATIENT REGISTRATION FORM

Warrnambool Medical Clinic by Lyndoch Living

Contact Information

Title: **Surname:** **Given Names:**

Date of Birth: Gender: Male: ☐ Female: ☐ Non-binary: ☐

Home Address: State: Post Code:

Postal Address: State: Post Code:

Home Phone: Mobile: Work:

Email: Occupation:

Healthcare Identifiers

Medicare Card Number: Reference Number: Expiry:

Pension Card No: Expiry:

Healthcare Card No: Expiry:

DVA Card No : Card Type: ☐ Gold ☐ White Expiry:

Emergency Contact Details

Name: Relationship to you:

Home Phone: Mobile: Work:

Next of Kin Details (if different to above)

Name: Relationship to you:

Home Phone: Mobile: Work:

Do you have an advance care directive for end of life care? Yes: ☐ No: ☐ Discuss further with your GP.

Cultural Background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐

Country of Birth

Other cultural background (e.g. Mediterranean Asian, African)

Is English your first language?

Yes: ☐ No: ☐

If not, do you require an interpreter?

Yes: ☐ No: ☐

Please specify language:

Religion: _____

Family Health History

Hypertension: ☐ Mental Illness: ☐ Cancer: type

Asthma: ☐ Heart Disease: ☐ Diabetes: ☐

Other:

Your Health Information

Allergy information:

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

No ☐

Yes, please provide details below including your reaction

Please list current medications, including complementary medicines.

Medical History - Do you have or have you had a history of the following?

Chronic Illness: ☐ Diabetes: ☐ Other:

Asthma: ☐ Hypertension: ☐ Surgery - provide details:

Lifestyle risk factors

Do you smoke? Never ☐ Currently ☐ Ex-smoker ☐

Do you consume alcohol? Never ☐ Not Currently ☐ Yes ☐

Consent

Please read and sign your acknowledgment below.
I hereby agree to pay all associated fees relating to my consultation. I acknowledge that if an account is overdue, Warrnambool Medical Clinic reserves the right to refer the account to a collection agency. I agree to meet all reasonable costs and commissions incurred in employing the said agency, to collect the overdue amount.

I agree:

To have my relevant invoicing, health reminders and results sent by SMS, email or post (eg pap smear/health check /diabetes/immunisations).
To have my de-identified records viewed for general practice accreditation/research purposes/quality assurance.
To have my health record shared with other health professionals to who I may have been referred.
To have My Health Record loaded to MyGov.

I have read and understood the above arrangements:

Patients Signature: _____ **Date:** _____

Please note if signatory is parent/guardian of the patient: _____

Warrnambool Medical Clinic by Lyndoch Living takes its obligations under the Health Records Act 2001 (Vic) and the Privacy Amendment *(Private Sector)* Act 2000 *(Commonwealth)* seriously and will take all reasonable steps in order to comply and protect the privacy of the personal information that we hold.

Warrnambool Medical Clinic by Lyndoch Living · RACGP | Member · Accredited General Practice · WE ARE PROUD TO BE AN ACCREDITED MURRAY CITY COUNTRY COAST GP TRAINING GENERAL PRACTICE TRAINING FACILITY · Lyndoch HealthCare