Mount Waverley Medical Centre

New Patient's Registration Form

TITLE : Mr/Mast/Mrs/Ms/Miss/Dr/Other

First Name _____ Family Name _____

Preferred Name _____ Date of Birth ___ /____/ _____ Sex : ◯Male ◯Female ◯Other

ADDRESS_____

Suburb/Town _____ State____ Postcode_____

MOBILE /HOME PHONE _____ Email address _____

Marital Status(Optional)_____ Occupation_____

ETHNICITY : Please chose one : ◯Aboriginal ◯Torres Strait Islander ◯Both ◯Neither

Country of Birth _____ Ethnic Background _____

Do you speak English ? Y/ N , Preferred language _____ Do you need interpreter? Y / N

NEXT OF KIN : First Name _____Family Name _____

Phone number _____Relationship to Patient _____

EMERGENCY CONTACT : First Name_____ Family Name _____

Phone Number _____ Relationship to Patient _____

PARENT/GUARDIAN (If child is under 16) : First Name _____ Family Name_____

Date of Birth __ /__ /_____, Medicare card _____ Reference Number ___

MEDICARE NUMBER _____ Reference Number __ Expiry Date ___/____

DO YOU HAVE CONCESSION CARD(Health care card/Pension concession card/Commonwealth senior card/DVA card(gold/silver/orange) **? Y / N**

If YES, please fill in the card type and number _____ Expiry Date __/____

HOW DID YOU FIND US?

◯Google Search ◯ Social Media ◯ Walk/Drive by ◯ Friends/Relatives /Word of Mouth

◯ Flyers ◯ Booking Apps(Healthengine…etc) Other _____

CONSENT FORM

*I HAVE READ THE BILLING POLICY , UNDERSTAND AND AGREE TO PAY THE COST OF MY TREATMENT

*I CONSENT TO THE USE MY MOBILE NUMBER FOR SMS OR EMAIL TO CONTACT ME FOR THE REMINDERS, RECALLS, HEALTH ALERTS AND/OR HEALTH NEWSLETTER

*I CONSENT TO PAY A NON-REBATABLE, NEW PATIENT'S REGISTRATION/ADMINISTRATION FEE OF $50.00 , PRIOR TO MY FIRST VISIT (FOR MEDICARE CARD HOLDER)

Patient Signature _____ Date _____

Parent/Guardian's Signature _____Date_____

HEALTH INFORMATION

Current Medication(Including complementary and over-the counter medicine(e.g.homeopatheic medicine such as vitamins and minerals)_____

Allergies: Y/N , If Yes _____

Smoking Status : Non-smoker/ Ex-smoker(Ceased date_____) / Smoker(number____/per day)

Do you drink alcohol? Yes/No, If Yes, how many standard drinks ____/per day

Recreational Drug use , No / Yes, If Yes, Type _____, frequency_____

Medical History: Surgery/Asthma/Diabetes/Hypertension/Chronic Illness/Others_____

Family History (Indicate which family member _____)

Surgery/Asthma/Diabetes/Hypertension/Chronic Illness/Others_____