359 Blackburn Rd, Mount Waverley VIC 3149

create fertility

NEW PATIENT REGISTRATION FORM

TODAY'S DATE: _____

Title: *(Please Tick)* ☐ Mrs ☐ Ms ☐ Miss ☐ Mr ☐ Dr

First Name _____ **Surname**_____

Middle Name _____ Known As _____

Address _____

Suburb_____ Post Code _____**Date of Birth** _____

Home Ph _____Work Ph _____**Mobile** _____

Email _____**Weight** _____ **Height**_____

Medicare No. ____/____/____/____/____/____/____/____/____/____/____ Ref No._____ Expiry Date_____

Private Health Fund _____ ☐ Uninsured

Fund Membership No. _____ With this Fund for more than 12 mths: ☐ YES ☐ NO

Vet Affairs Card No. _____ Expiry Date _____

Referral Source: ☐ Doctor ☐ Hospital ☐ Family ☐ Friend ☐ Other _____

Marital Status: ☐ Married ☐ De Facto ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Your current occupation: _____ ☐ Home Duties

Partners Name _____ Relationship to you _____ Date of Birth _____

Occupation_____ Mb _____ Hm _____ Wk _____

Next of Kin (Emergency Contact Person) Name:_____

Relation to you_____ Mb _____ Hm _____ Wk _____

GENERAL HEALTH: **MEDICATIONS** _____ **ALLERGIES** _____

Do you currently have, or have you suffered from the following:

- ☐ Heart problems
- ☐ Stomach or bowel problems
- ☐ Thyroid problems
- ☐ Hepatitis or H.I.V.
- ☐ Anaemia
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Lung problems
- ☐ Urinary or Bladder problems
- ☐ Stroke
- ☐ Thrombosis, clotting or DVT
- ☐ Diabetes
- ☐ Depression
- ☐ Psychiatric problems

TOBACCO (how many per week?) _____ ALCOHOL (How much weekly?) _____

PRIVACY STATEMENT: This medical practice collects information from you for the primary purpose of providing quality healthcare. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may use the information you provide for administrative purposes in running our medical practice, including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes.

I consent to the handling of my information by this practice for the purpose set out above. I understand my obligation with regard to payment of my account.

Print Name: _____ Signed:_____ Date: _____