DAREBIN INTEGRATIVE MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Personal Details

Title:_____ Given Name:_____ Family Name:_____

Date of birth: ____/_____/____

Gender: (Please circle) Male Female

Marital Status: (Please circle) Single Married Defacto Divorced Widowed

Cultural Background:
Are you of Aboriginal or Torres Strait Islander Origin? (Please circle)
No Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander

Country of Birth: _____

Address: _____ Suburb:_____

Postcode:_____ Home Phone: _____ Work Phone: _____

Mobile: _____ Email: _____

Occupation: _____

Medicare Number: _____ Ref No: _____

Expiry Date: _____

Pension/HCC No: _____ Expiry Date: _____

DVA (Veterans Affairs) No: _____ DVA Colour:
_____

Next Of Kin Details: (NOK) (Relation or Family Member)

NOK Name: _____ Relation to you: _____

NOK Address: _____

NOK Contact No: _____

Please turn over -->

Emergency Contact: (Different to NOK)

Name: _____ Relation to you: _____

Contact No: _____

Medical History: (Please circle)

Smoker Non-Smoker Ex- Smoker

Do you have any known allergies? (Eg. Medication, Food etc)

Allergy: _____Reaction: _____

Severity: _____

Current Medication: (Name, Date commenced, Dosage)

Privacy:
Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare services it is important that you are aware of how any personal information collected by this practice is used. The personal information collected is that deemed necessary to best attend to, and treat the presenting health condition(s). Personal information is primarily used within the practice, but sometimes it is used to ensure the quality and continuity of health care for you and must be partially or fully disclosed to others outside of the organisation, depending on the circumstances. E.g: when referring to a specialist medical practitioner or when requesting blood tests, urine tests, x-rays etc, when itemising accounts for Medicare.

Freedom of information:
All patient files that include personal information, test results etc, are the property of this practice. However, should you choose to visit another Doctor at any time, copies of the appropriate files can be forwarded on receipt of your written request. Under no circumstance will this practice divulge personal information without your prior written consent.

I have read & understood all information provided above regarding fees, privacy & freedom of information.

Name: _____ Signature: _____ Date: _____