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| ***Welcome to the Hills Medical***  ***Please complete and Give to Reception***  **NEW PATIENT REGISTRATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title |  | First Name | | |  | | | | | | | | | | | | | | middle initial | | | |  | | | | | Surname | | | | | | |  | | | | | |
| Known as | |  | | | | | | | | | Date of Birth | | | | | | | |  | | | | | | | | | | | | | | | | Male/Female/Other | | | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | | |  | |
| Postal | | *Write As Above if same as residential* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | | |  | |
| Ph Home | |  | | | | | | work | | | | | |  | | | | | | | | | | | | | mobile | | | | | | | |  | | | | | |
| Email Add | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Marital Status | |  | | | | | | Occupation | | | | | |  | | | | | | | | | | | | | | | Country of Birth | | | | | | | |  | | | |
| Aboriginal or Torres Strait Islander | | | Yes/No | | | | | | | | | | | | | Consent to SMS Communication | | | | | | | | | | | | | | | Yes/No | | | | | | | | | |
| Cultural/Religious background | | | is there anything we should know that will enable our practice team to remain respectful and considered during your health care visit ? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare No | | |  | | | |  | | |  | | |  | | | | |  | | |  | | | |  | | | | |  | | | |  | |  | | Ref No | |  |
| Pension / Health Care / DVA Card (please circle) | | |  | | |  | | |  | | |  | | |  | | | | |  | |  | | | |  | | | |  | | |  | | | Exp | | / / | | |
| **NEXT OF KIN ( Required)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship to Patient | | | |  | | | | | | | | | | | | | Is Next of Kin an Existing Patient? | | | | | | | | | | | | | | | Yes/No | | | | | | | | |
| Title |  | First Name | |  | | | | | | | | | | | | | | | Surname | | | | |  | | | | | | | | | | | | | | | | |
| Known as | |  | | | | | | | | | Date of Birth | | | | | | | |  | | | | | | | | | | | | | | | | Male/Female/Other | | | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | | |  | |
| Postal | | *Write As Above if same as residential* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | | |  | |
| Ph Home | |  | | | | | | work | | | | | |  | | | | | | | | | | | | | mobile | | | | | | | |  | | | | | |
| **EMERGENCY CONTACT ( If different to Next of Kin)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship to Patient | | | |  | | | | | | | | | | | | | Is Next of Kin an Existing Patient? | | | | | | | | | | | | | | | Yes/No | | | | | | | | |
| Title |  | First Name | |  | | | | | | | | | | | | | | | Surname | | | | |  | | | | | | | | | | | | | | | | |
| Ph Home | |  | | | | | | work | | | | | |  | | | | | | | | | | | | | mobile | | | | | | | |  | | | | | |
| **PLEASE SEE OVER** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- |
| Transfer of Health Information | * If you have consulted with another GP at another practice, the Health Information held by that GP may assist us with your future healthcare needs. If you wish to have a copy/summary of your health care records transferred to this clinic, please ask reception/GP for information on how this can take place. |
| Reminders & Recalls | * Our medical clinic automatically provides our patients with preventative care and early detection reminders |
| Payment Policy | * The Hills Medical is **NOT a bulk billing clinic** and out of pocket fees apply * Payment in full is requested at the time of consultation. * The patient will accept full liability for all **Workcover** and **TAC** claims * A $10 accounting fee will be charged if your account is not paid in full on the day of consultation |
| Privacy Policy | * The Hills Medical acknowledges and respects the privacy of individuals. The personal information collected is necessary for us to provide you with the best possible service. By completing this form, The Hills Medical accepts that you and/or your parents/guardians (if person is under 18 years of age) have consented for this information to be collected. The intended recipients of this information are The Hills Medical and its authorised staff. You have the right to access and alter personal information collected in accordance with the ***Commonwealth Privacy Act (Amended 2001)*** and The Hills Medical Privacy Policy. You may receive information from time to time regarding health issues and/or recalls. * I give my consent that information regarding my treatment be released to other Specialist practitioners and/or other The Hills Medical practitioners as necessary. |
| Medications | Please list your current medications and the conditions they relate to, including vitamins and natural medicines.   |  |  |  |  | | --- | --- | --- | --- | | **Medication** | **Condition** | **Mg / ml** | **Frequency** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   ­­­­­­­­­­­­­­­ |
| **Consent** | Please read carefully before signing. Your signature will be taken as your agreement to what is set out above  ………………………………………………….. ………………………………….  Name (please print) Date:  ………………………………………………………………  Signature |

How did you hear about The Hills Medical? *(please circle)*

Family Friend Yellow Pages Walk in Internet Advertising

Other: ...........................................................................................................................................................................................................................

