



The Hills Medical

485 Mount Dandenong Tourist Road, Olinda 3788

Ph: 9751 2333 Fax: 9751 2335

WELCOME TO THE HILLS MEDICAL PLEASE COMPLETE AND GIVE TO RECEPTION

NEW PATIENT REGISTRATION

TITLE/PRONOUN		FIRST NAME		MIDDLE INITIAL		SURNAME	
KNOWN AS				DATE OF BIRTH			
SEX ASSIGNED AT BIRTH				GENDER IDENTITY			
HOME ADDRESS						POSTCODE	
POSTAL	WRITE AS ABOVE IF SAME AS RESIDENTIAL					POSTCODE	
PHONE: HOME		WORK		MOBILE			
EMAIL ADDRESS							
IF PATIENT IS 13 – 17 YEARS PLEASE COMPLETE THE CONTACT DETAILS BELOW IF DIFFERENT FROM ABOVE (THESE DETAILS WILL BE USED FOR APPOINTMENT AND HEALTH REMINDERS)							
PHONE: HOME		WORK		MOBILE			
EMAIL ADDRESS				CONSENT TO SMS COMMUNICATION	Yes/No		
COUNTRY OF BIRTH				ETHNICITY			
CULTURAL/SEXUAL/RELIGIOUS BACKGROUND	IS THERE ANYTHING WE SHOULD KNOW THAT WILL ENABLE OUR PRACTICE TEAM TO REMAIN RESPECTFUL AND CONSIDERED DURING YOUR HEALTHCARE VISIT ?						
MEDICARE NO						REF NO	EXPIRY / /
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/PRONOUN		FIRST NAME		SURNAME			
KNOWN AS				DOB		GENDER:	
ADDRESS						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							



The Hills Medical

485 Mount Dandenong Tourist Road, Olinda 3788

Ph: 9751 2333 Fax: 9751 2335

TRANSFER OF HEALTH INFORMATION	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Our medical clinic automatically provides our patients with preventative care and early detection reminders Our clinic utilises HotDoc software to provide electronic communication via SMS or email regarding results, appointments and clinical reminders 																
PAYMENT POLICY	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<p>Please list your current medications and the conditions they relate to, including vitamins and natural medicines.</p> <table border="1"> <thead> <tr> <th>Medication</th> <th>Condition</th> <th>Mg / ml</th> <th>Frequency</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Medication	Condition	Mg / ml	Frequency												
Medication	Condition	Mg / ml	Frequency														
CONSENT	<p>Please read carefully before signing. Your signature will be taken as your agreement to what is set out above including electronic communication.</p> <p>..... Name (please print) Date:</p> <p>..... Signature</p>																
MY MEDICARE	<p>Would you like to register for My Medicare? YES/NO If yes, please ask reception team for an application form. For more information please read information provided at reception.</p>																

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

Family/Friend

Other Health Professional

Walk in/Local

Internet/HotDoc

Advertising

Other: