LIVING ROCK MEDICAL CENTRE

New Patient Registration

We are committed to providing our patients with the best care. To do this it is essential that your health record is up to date and accurate.

Could you please assist us by completing the following: **Date:**

Gender M F	☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Mast**		**Marital Status**
Surname			
First Name		**Middle Name**	
Preferred Name		**Date of Birth**	
Postal Address			
Residential Address			
Home Phone		**Mobile Phone**	
Interpreter service	No ☐ Yes ☐ If yes, which language?.....		

SMS reminders will be sent to all patients with mobile phones the day before their scheduled appointment. You can opt out of this service by advising our reception staff.

Occupation		Employment: Yes / No		
Email				
Medicare Number		**Ref. No.**	**Expiry Date**	
Private Health Fund	**Fund Name**	**Member no.**	**Expiry Date**	
DVA card Gold / White (Please circle)			**Expiry Date**	
Pension or Health care card number			**Expiry Date**	
Next of Kin Name/phone/relationship				
Emergency Contact Name/phone/relationship				
Your GP – Name, Clinic Phone				

Is this a Work Cover/Third Party Claim? *Please circle as appropriate* (***if yes, please ask our front desk staff for the workcover form & return the completed form)***	Yes	No

To assist with health initiatives please advise your ethnicity:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

☐ Australian ☐ Other – Please Specify_____ **PTO**

WHO WILL BE RESPONSIBLE FOR PAYING YOUR ACCOUNT?:

☐ Self

☐ TAC Date of Accident:……

Claim Number:……

☐ Workcover VIC / NSW / SA Date of Injury:……

OLD / TA/ WA Claim Number:……...

Confirmed with employer Yes / No Insurance Company:…….

Employer's Name:……

Employer's Phone Number:……

Occupation: ……

Work contact person's name & phone:……

☐ Others: ……..

Do you have any allergies or are you sensitive to drugs or dressings:

Yes ☐ (please list:……..……..) ☐ No

Social History

☐ Tobacco _____ daily / weekly or Ceased Smoking – date _____

☐ Alcohol _____ daily / weekly / monthly (circle applicable)

☐ Drug use _____ (type and frequency)

Height: _____ cms **Weight:** _____kgs

For those 65 years and older: when was the last time you had:

Influenza vaccine	Date _____	☐ Not sure	☐ Never
Pneumococcal pneumonia vaccine	Date _____	☐ Not sure	☐ Never

Females: when did you last have

Pap smear	Date _____	☐ Not sure	☐ Never

Males: when did you last have

An overall check-up	Date _____	☐ Not sure	☐ Never

I understand that payment of all accounts is my responsibility. All accounts, other than account which are bulk billed to Medicare or which are billed to other Third party payers, are payable in full at the time of treatment. For your convenience, we can accept cash, EFTPOS, Visa & MasterCard. I understand that in the event that accounts which are bulk billed to Medicare or which are billed to other Third party payers are not honoured by such payers then payment of such accounts is my responsibility. I also undertake to pay any debt collection & legal costs that may be incurred by Living Rock Medical Centre as a result of late payment or non-payment of accounts

By signing this document, you are consenting to the release and receiving of medical information **relevant to your care and treatment** between health service providers. Please advise reception if you do not want medical information released or received by this clinic.

Date: ___/___/_____ Name---------- Signature: ----------

Preventative Care Status

Nutrition

……

……

……

……

Physical activity

……

……

……

……

Blood pressure = ……

Height = ……..

Weight = ……

Body Mass Index (BMI) = ……

Date of last immunisation = ……

My Health Record:

Do not send my health information to My Health Record ☐

Patient Consent Form – Third Party

Staff at Living Rock Medical Centre are required to seek patient consent for the presence of a third party during their consultation. A patient is entitled to either consent to, or decline the presence of a third party.

Please complete this form to indicate your consent/decline to the presence of a third party during your consultation.

Patient Consent Details:

I, _____
(patient's first/given names) *(Surname)*

☐ Have requested the presence of my spouse, family member, guardian, friend, carer, interpreter or chaperone, during my consultation.

OR

☐ Understand that the general practitioner has requested presence of a third party being an interpreter, medical or allied health or nursing professional or student, general practice registrar or chaperone, during my consultation.

AND

Consent to having a third party present during my consultation: _____

(signature) *(date)*

OR

Decline having a third party present during my consultation: _____

(signature) *(date)*