Total Care Medical Centre

194-196 Karingal Drive, Frankston, Vic 3199
Tel: 03 9789 1666 Fax: 03 9789 3122

New Patient Registration Form

Title:____FirstName:_____FamilyName:_____Dateof Birth: ____/____/___

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref Number (next to name on card):___ Expiry: ____/____

Please Circle
Pension/Health Care Card Number:_____ Exp:___ /___/___

DVA(VeteranAffairs)Gold/White:_____Expiry:_____Occupation_____

Address:_____Suburb:_____Postcode:_____

Home Phone:_____ Mobile:_____ Business:_____

Email_____

NextofKin:_____Relationship:_____Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____

Are you an Aboriginal/Torres Strait Islander Yes / No (please circle)

Country of Birth: _____Year of Arrival:_____

Current Medications:_____

Allergies:_____**Reaction:** _____

Do you currently smoke? YES/NO Are you an Ex smoker? YES/NO Do you drink alcohol? YES/NO

How many per day? _____ Quit Date _____ How often? _____

Have you ever had or have any of the conditions below? If yes (please circle)

Diabetes Kidney disease Asthma Bowel Cancer Breast Cancer High blood Pressure Heart Problems Epilepsy

Other:_____

Is there a family history of any of these conditions?

Diabetes Kidney disease Asthma Bowel Cancer Breast Cancer High blood Pressure Heart Problems Epilepsy

Relationship to you _____

PRIVACY

We must obtain your consent for messages to be left on your telephone or mobile answering or message bank regarding matters involving your health. Do you agree ? **YES/ NO**

REMINDER SYSTEM

Our practice provides our patients with preventative care and early case detection reminders eg: immunisations, annual health checks, skin checks and pap smears.

Do you agree for reminders to be sent to you by mail or SMS YES / NO

CONSENT

I consent to the collection, use and handling of my information by the practice set out in the Practices privacy policy.

I consent to the above and have read the Practice Privacy policy and consent to my information being released as outlined in the policy.

Name:_____

Signature:_____Date_____