Stawell Medical Centre
26 Wimmera Street
PO Box 800
Stawell VIC 3380
Tel: (03) 5358 1410
Fax: (03) 5358 4196

New Patient Registration Form

Personal Details:

Title:_____ **Name:**_____

DOB:_____ **Birth Sex:**_____ **Gender Identity:**_____

Ethnicity:_____ **ATSI Decent: YES / NO Specify** _____

Residential Address:_____

Postal Address:_____

Phone: (H)_____**(M)** _____**(W)** _____

Email Address: _____

Medicare No:_____ **No. Next to Name:**_____ **Exp:**_____

Pension/Health Care Card (please circle) No:_____ **Exp:**_____

DVA No:_____ **Card Colour:**_____

Health Fund: _____ **Member No:**_____

Next of Kin Name:_____ **Relationship**:_____

Next of Kin Contact Number:_____

Emergency Contact:_____ **Relationship:**_____

Emergency Contact Number:_____

Occupation:_____ **Known Allergies:**_____

Medical Background:

Alcohol: Y / N____ Per Day/Week (please circle) **Smoker:** Y / N _____ Per Day/Week (please circle)

Exercise: Y / N____ Per Day/Week (please circle) **Type of Exercise:** _____

Past Personal History / Significant Family History

_____

_____

_____

_____

Allergies and Medicines:

Please list your regular Medications and dosages

_____

_____

_____

Please list any Allergies and intolerances you have to any medications

_____

_____

_____

Please Describe your reaction

_____

_____

_____

Female patients only:

Last pap smear/cervical screen: _____

Last mammogram (If over the age of 50) _____

Male patients only:

Last prostate blood test: _____

Last Bowel Cancer Screen (If over the age of 50) _____

Do you have a Medical Power of Attorney? Yes ☐ No ☐

Name of POA: _____ **Contact Phone Number**:_____

Has a Copy of your POA been supplied to Stawell Medical Centre? Yes ☐ No ☐

Do you have an Advanced Care Directive for end of life care? Yes ☐ No ☐

Has a Copy of your ACD been supplied to Stawell Medical Centre? Yes ☐ No ☐

Consent:

Would you like SMS Enabled for Appointment & Clinical Reminders? Yes ☐ No ☐

Do you require a Phone Reminder required for Appointments? Yes ☐ No ☐

Results
It is the policy of this practice not to inform you of your results over the phone. Urgent matters and reminders will be dealt with in accordance with our recall and reminder policies.

Your Privacy is our Concern
In accordance with the Privacy Act, all information collected in this practice is treated as confidential information. To protect your privacy, this practice operates in accordance with this act.

Transfer of Health Information
You may wish to have a copy or summary of your health records transferred to this practice. Please ask at reception for information about how this can take place.

My Health Record
By signing this form, you acknowledge that you give permission for your Doctor to upload to your eHealth/My Heath Record. If you do not consent to the participation in MHR, please tick this box ☐

I have read and understood the above information.

Signed_____ Date_____