

PATIENT REGISTRATION FORM											
Given Name:			Surname:			Known As:		DOB:			
Medicare No:		Reference No: Exp:		: Aborig		ginal or Torres Strait Islander? YES/NO					
Where did you find out about us?			Address:								
·	Suburb:				Postcode:		Occupatio		on:		
<ul><li>□ Friend/Relative</li><li>□ Local Business</li></ul>		PHONE H:			W:				M:		
<ul><li>☐ Work Place</li><li>☐ Driving Past</li></ul>			Email (This will <u>not</u> be used for marketing purposes):								
<ul><li>☐ Internet</li><li>☐ Yellow Pages</li><li>☐ Hospital</li></ul>	EMERGENCY CONTACT Name:										
	Relationship to You:						Number:				
	Healthcare Card/Pension No: Exp:										
other (Speeny).	Veterans Affairs Number: Exp:								Ехр:		
Are you ALLERGIC or sensitive to any medic Please list:							lications? (YES/NO)				
			PAST H	HIST	ΓORY						
GENERAL	Do you have any RELEVANT prior history?										
Do you or have you had											
When was your Are you married / de facto / single? (Please Circle) Ethnicity Last Pap Smear?						chnicity:					
	No:  Id you find out about us?  riend/Relative ocal Business Vork Place Oriving Past Internet Fellow Pages Hospital Other (Specify):  GENERAL have you had d Pressure? YES / NO	Given Name:  No:  Id you find out about us?  Address  Suburb  PHONE  PHONE  PHONE  PHONE  PHONE  Email (*  EMERG  Relation  Are you  Please I  Syour  Are you  Syour  Are you  Are you  Are you  Are you  Syour  Are you  A	Given Name:  No:  Refer  Address:  Suburb:  riend/Relative ocal Business  Vork Place Oriving Past Internet Fellow Pages Iospital Other (Specify):  GENERAL have you had d Pressure? YES / NO  Refer  Address:  Suburb:  Email (This wi EMERGENCY Relationship t Healthcare Ca Veterans Affa Are you ALLE Please list:  Do you have a Please list:	Given Name:  No:  Reference No:  Address:  Suburb:  PHONE  PHONE  Email (This will not be used EMERGENCY CONTACT  Relationship to You:  Healthcare Card/Pension Nother (Specify):  Weterans Affairs Number:  Are you ALLERGIC or sensing Please list:  PAST F  GENERAL  have you had depressure? YES / NO  Are you married / de factors  Reference No:  Reference No:  Address:  Suburb:  Email (This will not be used EMERGENCY CONTACT  Relationship to You:  Healthcare Card/Pension Nother (Specify):  PAST F  GENERAL  Are you have any RELEVAN Please list:	Given Name:  No:  Reference No:  Reference No:  Exp  Address:  Suburb:  PHONE  PHONE  Email (This will not be used for m  EMERGENCY CONTACT  Name:  Reference No:  Exp  Address:  Suburb:  PHONE  Email (This will not be used for m  EMERGENCY CONTACT  Name:  Relationship to You:  Healthcare Card/Pension No:  Veterans Affairs Number:  Are you ALLERGIC or sensitive to Please list:  PAST HIST  GENERAL  have you had d Pressure? YES / NO  Are you married / de facto / sing	Given Name:  No:  Reference No:  Reference No:  Exp:  Address:  Suburb:  Postcoor  Suburb:  PHONE  H:  Email (This will not be used for marketing because	Given Name:   Surname:   Known	Given Name:    Surname:   Surname:   Known As:	Given Name:  No:  Reference No:  Exp: Aboriginal or Torre  Address:  Suburb:  Postcode: Occupation  Occupation  Phone  H: W:  Email (This will not be used for marketing purposes):  EMERGENCY CONTACT Name: Relationship to You: Number:  Healthcare Card/Pension No: Veterans Affairs Number: Are you ALLERGIC or sensitive to any medications? (YES/NO)  Please list:  PAST HISTORY  Do you have any RELEVANT prior history? Please list:  FAMILY HISTORY  Are you married / de facto / single? (Please Circle)  Ethnicity:	Given Name:    Surname:   Surname:   Known As:   DOB:	

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GENERAL  Do you or have you had  High Blood Pressure? YES / NO		Do you have any RELEVANT prior history? Please list:  FAMILY HISTORY						
Do you take regul Please list:	ar Medication?	How many CHILDREN do you Boys: Age(s): Girls: Age(s): Has any member of your family bee diagnosed with Diabetes, a heart co	n ndition,	Are your parents still alive?  Mother YES / NO Current Age: Father YES / NO Current Age:  If deceased please state at what age and cause of death:				
Are you Diabetic? YES / NO		2.0004 20.00 0.00 0.00 0.00 0.00		cause of acati.				
Height	Weight	SOCIAL HISTORY						
Body Mass Index:		Do you smoke? Have you smoked previously?	YES / NO YES / NO	How many per day/week? When did you give up smoking?				
Blood Pressure:		Do you drink alcohol?  Do you smoke marijuana?	YES / NO YES / NO	How many per day/week?  If so how often?				

Patient consent: I understand that Toorak Village Medical Centre (TVMC) is committed to protecting the privacy of individuals and their personal information in accordance with the *Privacy Act 1988* (Cth). My signature below indicates that I consent to TVMC collecting, using, disclosing, storing and disposing of my personal information for the purposes set out in TVMC Privacy Policy, including but not limited to the provision of medical services and treatment to me and to enable me to be attended by medical practitioners within TVMC; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits, medical updates and health information; for the purposes of data research and analysis including conducting clinical trials and proactive screenings; and the release of relevant personal information to my employer or prospective employer, their authorised representative and their insurer in the case of a work related consultation or service only. I understand I may withdraw my consent for TVMC to use and disclose my personal information (except when legal obligations must be met).

Signature:	Date:
3	