Toorak Village Medical Centre
ABN: 59 248 163 575

PATIENT REGISTRATION FORM

Title:	Given Name:	Surname:		Known As:	DOB:
Medicare No:		Reference No:	Exp:	Pronouns (please circle): he/him/his; she/her/hers; they/them/theirs	

Where did you find out about us?

- ☐ Friend/Relative
- ☐ Local Business
- ☐ Work Place
- ☐ Driving Past
- ☐ Internet
- ☐ Yellow Pages
- ☐ Hospital
- ☐ Other (Specify):

Aboriginal or Torres Strait Islander? YES / NO		Gender identity:	
Address:			
Suburb:	Postcode:		
PHONE	H:	W:	M:
Email:		Occupation:	
EMERGENCY CONTACT	Name:		
Relationship to You:		Number:	
Healthcare Card/Pension No			Exp:
Veterans Affairs Number:			Exp:
Are you ALLERGIC or sensitive to any medications? YES / NO Please list:			

PAST HISTORY

GENERAL

Do you or have you had High Blood Pressure? YES / NO

When was your Last Pap Smear?

Do you take regular Medication? Please list:

Are you Diabetic? YES / NO

Do you have any RELEVANT prior history?
Please list:

FAMILY HISTORY

Relationship status: married / de facto / same sex partner / single? (Please circle)

Ethnicity:

How many CHILDREN do you have?
Boys: Age(s):
Girls: Age(s):

Has any member of your family been diagnosed with Diabetes, a heart condition, Breast, bowel or other form of cancer?

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:

Height: Weight:

How many times per week do you exercise for 30 mins or more?

Blood Pressure:

SOCIAL HISTORY

Do you smoke?	YES / NO	How many per day/week?	
Have you smoked previously?	YES / NO	When did you give up smoking?	
Do you drink alcohol?	YES / NO	How many per day/week?	
Do you smoke marijuana?	YES / NO	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: .....**