BALWYN CENTRAL MEDICAL

HEALTH GROUP

Once Completed Please Hand This Registration Form To Reception

PATIENT INFORMATION

Title:	Name:	Surname:	D.O.B:

Phone; H: M: W:	Address: Postcode:	Occupation:

Are you Aboriginal or Torres strait islander? ◯ Yes ◯ No
Are you of Aboriginal or Torres strait islander origin? ◯ Yes ◯ No

Ethnicity/Nationality:

Email:

If you have one of the cards below, please write down the card number and expiry

◯ Centrelink health care card:
◯ Centrelink pension card: Number: Expiry:
◯ Centrelink Seniors health card:
◯ Dept. of Veteran Affairs (DVA) Gold Card:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ De facto

I give permission for Balwyn Central Medical to contact me via:

SMS ◯ YES ◯ NO

EMAIL ◯ YES ◯ NO

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship:	Contact details:	Work phone no:

I understand that Balwyn Central Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Balwyn Central Medical collecting, using, storing and disposing of my personal information; 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: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Balwyn Central Medical to use and disclose my personal information (except when legal obligations must be met).

Patient / Guardian signature: Date:

Please tell us how you have heard about us:

◯Family/Friend ◯Google ◯Health Engine ◯ Hot-Doc ◯ Facebook ◯ Instagram ◯ Catalogue/Flyer ◯ Driving past

Do you know about My Health Record? ◯ Yes ◯ No (If not, please ask our friend reception staff)

Would you like our Clinical/admin staff to register you for My Health Record ◯ Yes ◯ No

CONFIDENTIAL MEDICAL HISTORY QUESTIONAIRE

Once completed please hand this to your doctor

Seen By **Doctor** _____

Scanned ☐

Patient name: _____ Date of Birth: _____

What medical concerns do you wish to discuss with your doctor today?

_____

Past Medical History: Has your child suffered from any of the following – currently or previously, **what year**?

☐ Heart Problems	☐ Blood clots	☐ Epilepsy / seizures	☐ Asthma
☐ Diabetes	☐ Eye Problems	☐ Thyroid Problems	☐ Bronchitis / bronchiolitis
☐ Liver Disease	☐ Kidney disease	☐ Fractures	☐ Developmental issues

☐ Any other? _____

Has your child had any operations or hospital admissions? **Yes / No**

If yes, please provide details

_____

Are your child's immunisations up to date? **Yes / No**

If no, please provide details

_____

Medications and Social History

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other ''natural'' remedies or supplement

MEDICATION	DOSE	FREQUENCY

FAMILY HISTORY:	MOTHER Alive (Yes / No)	FATHER Alive (Yes / No)	SIBLINGS
Heart Attack	☐	☐	☐
Bowel Cancer	☐	☐	☐
Breast Cancer	☐	☐	☐
High blood pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
Arthritis - Osteoarthritis/Rheumatoid?	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
Hemochromatosis	☐	☐	☐
Osteoporosis	☐	☐	☐
Other:	☐	☐	☐

ALLERGIES

_____
_____
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The Information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Parent / Guardian Signiture_____ Date_____