Appletree Hill Medical Clinic

a: 888 High St Rd, Glen Waverley VIC 3150
p: +61 3 9803 5494 f: +61 3 9803 9712
w: www.appletreehillmc.com

New Patient Registration Form

PERSONAL DETAILS	
Please circle Mr/Mrs/Ms/Miss/Master/Other	Date of Birth:
Sex: Female / Male	
First Name:	Middle Name:
Surname:	Preferred Name:
Phone Number Home:	Mobile:
Email:	
Occupation:	
Address:	
Suburb:	Post Code:
Medicare Card No:	
Ref No: (on card next to your name)	Expiry Date:
Concession (please circle): Pension Card / Low Income Healthcare Card / Veterans Affairs (Gold or White)	
Concession Card No:	Expiry Date:
CULTURAL BACKGROUND	
Are you of Aboriginal or Torres Strait Islander descent? YES / NO	YES / NO
Country of Birth:	Ethnicity:
Language Spoken:	Interpreter needed: YES / NO

Appletree Hill Medical Centre is committed to delivering safe and high-quality healthcare to our patients by complying with the Australian General Practice Accreditation Limited (AGPAL) Standards for general practices.

Accredited General Practice

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For parents/guardians registering children only

Parent/Guardian Name:	D.O.B:
Medicare number:	Expiry Date:
Ref No: (on card next to your name)	
WHO CAN WE CONTACT IN CASE OF EMERGENCY?	
Name:	
Relationship to you:	
Telephone Number:	Mobile Number:

TRANSFER OF HEALTH INFORMATION
You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy, or a summary of your health records transferred to this practice. Please ask the receptionist for more information.
DISCLOSURE
We need this information to provide the best quality care. This form complies with the RACGP Standards for general practices. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. Please advise us if your contact or Medicare details have changed. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.
MEDICAL HISTORY
Do you have any history of illness in the family?
Do you have any allergies?
History of operations/ procedures and major illnesses (include approx. year/s)
Regular medications & doses:
CONSENT
Our Practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap Tests and other health reviews.
I consent to being contacted with reminders to help me maintain my health. YES / NO

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Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders which can be helpful if you move.
I consent to being contacted with reminders to help me maintain my health. YES / NO
PRIVACY STATEMENT
Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised personnel. The practice adheres to a strict Privacy Policy. By signing below you are consenting to the terms and conditions as set out in our "Health Information Collection and Use" form (both are available from reception and on our website).

SIGNATURE OF PATIENT OR PARENT/GUARDIAN	
Date:	