CHELSEA ARCADE MEDICAL

NEW PATIENT REGISTRATION FORM

Title: _____

Name: _____

Date Of Birth: _____ Email: _____

Patient Address: _____

Phone: _____ Mobile: _____ Gender: _____

Occupation: _____ Ethnicity / Nationality: _____

Medicare #: _____ IRN: _____ Expiry: _____

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ De-facto

I permit Chelsea Arcade Medical to contact me via SMS ☐ Yes ☐ No

I permit Chelsea Arcade Medical to contact me via E-mail ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Details: _____ Work Phone: _____

NEXT OF KIN CONTACT

Name: _____ Relationship: _____

Contact Details: _____ Work Phone: _____

Do you hold any of the below cards? If so please provide details

☐ Centrelink Health Care Card
☐ Centrelink Pension Card
☐ Centrelink Senior Health Card
☐ Dept. of Veteran Affairs (DVA) Gold Card

Card Number

_____

Expiry

_____

I understand that Chelsea Arcade 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 Chelsea Arcade 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 Chelsea Arcade Medical to use and disclose my personal information (except when legal obligations must be met).

Patient / Guardian Signature: _____

How did you hear about us? ☐ Family ☐ Friend ☐ Google ☐ Hotdoc ☐ Health Engine ☐ Facebook ☐ Instagram ☐ Other: _____

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

Would you like our Clinical/Admin staff to register you for My Health Record ☐ Yes ☐ No
(Please ask a form to fill out from Reception)

CHELSEA ARCADE MEDICAL

Seen by Doctor

_____

Scanned ☐

ONCE COMPLETED PLEASE HAND THIS FORM IN TO YOUR DOCTOR

Patient Name: _____ Date Of Birth: _____

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

_____

Past Medical History: Have you suffered from any of the following – currently or previously, what year?

- ☐ Heart Problems
- ☐ Epilepsy
- ☐ Back Pain
- ☐ Liver Disease
- ☐ HIV
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Anxiety / Depression
- ☐ Eye Problems
- ☐ Kidney Disease
- ☐ Other: _____
- ☐ Hep B
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Blood Clots
- ☐ Bronchitis
- ☐ Hep C
- ☐ Fractures
- ☐ Glaucoma
- ☐ Diabetes

ALL

- ☐ Bowel Screening

Date: _____

- ☐ Skin Check

Date: _____

- ☐ Unintended Weight Change

Date: _____

FEMALE

- ☐ Pap smear

Date: _____

- ☐ Mammogram

Date: _____

- ☐ Health Check

Date: _____

Immunisations: _____

MALE

- ☐ Prostate Check

Date: _____

- ☐ Testis Check

Date: _____

- ☐ Health Check

Date: _____

Immunisations: _____

ANY ILLNESSES, OPERATIONS, HOSPITAL ADMISSIONS

Medications and Social History: Please include ALL tablets, inhalers, patches, gels or injections – as well as any other "natural" remedies or supplements

MEDICATION	DOSE	FREQUENCY

- ☐ Smoker

Per Day: _____

Start Date: _____

- ☐ Used to Smoke

Quit in: _____

- ☐ Non-Smoker

- ☐ Alcohol

Per Week: _____

Drinks Per Day: _____

- ☐ Rec. Drugs

Specify: _____

- ☐ Non-Drinker

FAMILY HISTORY	MOTHER ALIVE (Y/N)	FATHER ALIVE (Y/N)	SIBLINGS
Heart Attack	☐	☐	☐
Bowel Cancer	☐	☐	☐
Breast Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
Arthritis - Osteoarthritis/Rheumatoid?	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
Hemochromatosis	☐	☐	☐
Osteoporosis	☐	☐	☐
Other	☐	☐	☐

ALLERGIES

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

Parent / Guardian Signature: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY QUESTIONS

HEALTH GROUP

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