**SCOTT STREET MEDICAL CENTRE - PATIENT REGISTRATION FORM** DR..... (Initials)

33 Scott Street Melton Vic 3337 → Phone (03) 9743 1970 – Fax (03) 9743 4910

□ New Patient □ Update Existing File (Tick relevant box)

We are committed to providing our patients with the best care. It is essential that your medical records are up to date and accurate.

## Personal Details (Please tick relevant boxes)

Title □Mr □ Mrs □Ms □Miss □Mast □Other

Family Name: (Surname) .....

Given Name (First name) ..... Middle Name : .....

Date of Birth: ...../...../.....

Birth Sex: Male □ Female □ Unknown □ Other □ (please specify) .....

Gender Identity: Male □ Female □ Transgender □ Gender Diverse □ Different Identity □

Ethnicity: Australian, (non indigenous) □ Other □ (please specify) .....

Do you Identify as: Aboriginal not Torres Strait Islander □ Torres Strait Islander but not Aboriginal □

Both Aboriginal & Torres Strait Islander □ Non Aboriginal / Torres Strait Islander □ Not provided □

Street Address: .....

..... Suburb: .....

Postcode: ..... Postal Address: (if different): .....

Mobile Phone: ..... Home: ..... Work: .....

Email: .....

Contact Via: (Tick preferred method of contact) Mobile Ph □ Work Ph □ Home Ph □ SMS □ Email □ Letter □

Occupation: ..... STUDENT □ PENSIONER □ RETIRED □ HOME DUTIES□ UNEMPLOYED □

Medicare Card..... Ref No..... Expiry Date: ...../...../.....
DVA (Dept of Veteran Affairs) .....Expiry Date: ...../...../.....
Pensioner Concession Card : ..... Expiry Date: ...../...../.....
Health Care Card : ..... Expiry Date: ...../...../.....
Commonwealth Senior Card ..... Expiry Date: ...../...../.....
NO MEDICARE CARD □ PRIVATE PATIENTS / OVERSEAS VISITORS TO TICK THIS BOX

Next of Kin: ..... Phone: ..... Relationship: .....
Emergency Contact: ..... Phone: ..... Relationship: .....

Reactions : Do you have any allergies to medicines or are you sensitive to any dressings? Yes □ □ No □

| ALLERGY / INTOLERANCES | REACTION | SEVERITY | | |
|---|---|---|---|---|
| | | □MILD | □MODERATE | □SEVERE |
| | | □MILD | □MODERATE | □SEVERE |
| | | □MILD | □MODERATE | □SEVERE |

Significant Family History

Mother: Diabetes □ Hypertension □ Heart Disease □ Stroke □ Colon Cancer □ Depression □ Breast Cancer □

Other (please specify) .....

Father: Diabetes □ Hypertension □ Heart Disease □ Stroke □ Colon Cancer □ Depression □

Other (please specify) .....

Personal History (Forms part of Social History)

Diabetes Type 1 □ Diabetes Type 2 □ Cancer □ High Blood Pressure □ High Cholesterol □ Stroke □ Epilepsy □

Depression/Anxiety/Mental Illness □ Asthma □ Blood Clots □ Heart Disease □ Migraine □

Other (please specify) .....

Are you currently using any prescribed or over the counter medications or vitamins and minerals?

No □ Yes □ (please list): ..... *PTO*

**Social History**

**Martial Status:** **Single □** **Married □** **De Facto □** **Divorced □** **Separated □** **Widowed □**

**Lives with:** **Spouse □** **Partner □** **Relative □** **Friend □** **Alone □** **Other □ ……**

**Current Alcohol Intake** **Non Drinker □** **Yes □** **How many days per week? ……**
**How many standard drinks per day? ……**

**Past Alcohol Intake** **Nil □** **Occasional □** **Moderate □** **Heavy □**
**Year Started ……** **Year Stopped ……**

**Current Smoking History** **Non Smoker □** **Ex Smoker □** **Yes - Smoker □**
**If you are a smoker, what do you smoke? (Tick what is applicable)** **Cigarettes □** **Cigars □** **Pipe □**

**How many cigarettes per day? ……** **Year Started : ……..**

**Past Smoking History**
**Quantity per day** **Unknown □** **<1 □** **1-9 □** **10-19 □** **20-39 □** **40+ □**
**Year Started ……** **Year Stopped ……**

**Do you use recreational drugs?** **No □** **Yes □** **How Often? ……** **What Type? ……**

□ CONSENT FOR THIRD PARTY TO BE PRESENT DURING CONSULTATION OR TREATMENT
Eg: Medical Student, Nursing Student, Trainee Doctor (GP), Interpreter etc.
***(Please advise Reception if this decision changes in the future)***

**YES** ☐ **NO** ☐

It is our **Practice Policy** that patient's **will not** be **prescribed** any of the **drugs listed below.** Therefore, please be kind enough to make your own arrangements for these needs.

| | | | |
|---|---|---|---|
| 1 | Oxycontin | 9 | Mogadon (Nitrazepam) |
| 2 | Oxynorm | 10 | Flunitrazepam (Hypnodorm) |
| 3 | Endone | 11 | Rivotril (Clonazepam) |
| 4 | Methadone | 12 | Oxazepam (Murelax, Serepax) |
| 5 | Morphine (Kapanol, Ms Contin) | 13 | Dexamphetamine |
| 6 | Alprazolam (Xanax, Kalma) | 14 | Methylphenidate (Ritalin, Concerta, Attenta) |
| 7 | Valium (Diazepam, Antenex) | 15 | Fentanyl (Durogesic) |
| 8 | Temazepam (Normison) | 16 | Buprenorphine (Norspan, Subtex, Suboxone) |

This policy exists to care for and for protection of patients, community and doctors.
Please do not be offended if your request is refused under the above conditions. All our staff have been instructed to treat our patients with respect and courtesy whatever their requests. Similarly, we ask for respect and courtesy from our patients.
When prescribing or supplying medications the doctors take all reasonable steps to ensure a therapeutic need exits and doctors do not prescribe to support drug dependence.
It is the **patients responsibility** to give a **complete and accurate medical history to the doctor** and it an offence **not** to do so with the purpose of obtaining drugs.

**Abuse of any sort will not be tolerated by our clinic against our staff and may result in care not being provided at all and further informing the police department**.

**I, ……,** declare that I have read and understand **Scott Street Medical Centre's Practice** Policy on not prescribing drugs listed above and will abide by their policy.

**Patient/Parent/Guardian Signature** …… **Date ……/……/……**

**PRIVACY POLICY**: Your medical record is a confidential document. It is the policy of this practice to maintain security of your personal health information at all times and to ensure this information is only available to authorised members of staff.

IMPORTANT : Please consider your own privacy if you choose to take a **family member / friend** into your consultation as the Practice will interpret this as your implied consent. By completing this patient registration form, we will also interpret this as implied consent to share your Health Information with **our sister clinic, Robin Street Medical Centre** if it is required to do so. Please be kind enough to inform Reception if you do not wish to consent to data sharing.

Our practice's full **Privacy Policy** leaflet is available to all our patients at Reception. It explains how personal information regarding you and your health is recorded and managed in this practice. Should you require further information, please see our Practice Manager or Assistant Practice Manager.

**Updated 10.06.21**