MEDICROSS NEW PATIENT REGISTRATION

Please print and give as much detail as possible to assist us to provide quality care.

A. PERSONAL DETAILS:

Mr Mrs Ms Miss Dr Surname: ________________________________ Given Names: _____________________

Preferred Name: _________________________________ Date of Birth ______/_____/_______

Medicare or Vet Affairs No.________________________________Ref _______ (next to name) Exp:___________

Pension/Healthcare Card No.____Exp:___________

Address:____Suburb:__________________ Postcode:_________

Postal Address (if different): ____

Home Phone: _______________________ Mobile: _________________________Work: ___________________

Email Address: ____

Emergency Contact Person:____ Relationship: _________________

Contact Phone: __________________________ How did you hear about us? ____________________________

Do you give permission for us to contact the above person in the event that we cannot reach you? **YES / NO**

Do you require your records to be transferred from your previous medical practice? **YES / NO**

B. FAMILY (Children under 16 only)

Name: ____ DOB:____/____/____ Medicare Ref: _______

Name: ____ DOB:____/____/____ Medicare Ref: _______

Name: ____ DOB:____/____/____ Medicare Ref: _______

C. CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs

Do you identify as an Aboriginal and/or Torres Strait Islander? **YES / NO**

IF YES, are you registered for 'Closing the Gap' PBS co-payment relief? **YES / NO**
(If no, and you are interested in finding out more information please ask at reception)

D. CONSENT

Our practice uses reminder systems to help you maintain your health. The practice may send reminders by post email and/or telephone for procedures such as vaccinations, Pap Smears and other health services. Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders.

I understand by indicating signing below that the Practice is authorized on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

SIGNATURE: ____ **DATE**: __________________

PRACTICE POLICY AGREEMENT

By becoming a patient of Medicross and signing below I have read and agree to the following:

- Standard appointments are 10 minutes and generally cover one health concern. If you have **more than one health concern**, a complex health issue or require a longer appointment for any other reason please notify reception at the time of booking. A separate appointment must be made per person/family member. This will assist the doctors with running on time.

- Patients that fail to attend an appointment without notice may incur a $60 fee and will be unable to attend the practice until the account is paid.

- **An appointment must be made** with a doctor to obtain results, repeat prescriptions or referrals. Results will not be given over the phone.

- Patients who are late to their appointment may have to wait until other patients who arrived on time are seen or in some cases reschedule the appointment altogether; this is at the discretion of the doctor.

- Doctors at this practice do not prescribe schedule 8 drugs and have a no tolerance policy to doctor shoppers and drug seekers. Doctors have the right to refuse the request of prescription drugs.

- This practice has a no-tolerance policy to aggressive or abusive behavior. Patients who are physically or verbally aggressive to staff will be banned from the practice at the discretion of the doctor or practice manager.

- It is at the discretion of the doctor and practice staff to provide personal health information to parents/guardians of patients under the age of 16. All patients 16 and over are considered adults and information will not be disclosed to parents/guardians/friends/spouse without permission from the patient. If you would like to nominate a person to have access to your health information and communicate with us on your behalf please ask reception for a **Third Party Access Consent form.**

Name of Patient (please print): ……….…

Signature of Patient: …….…

Print name and signature of Parent /Guardian (if under 16): ……………………………………………………………………….……………..

Date : ………………………………………………………..

medicross medical

MEDICAL HISTORY FORM
Medicross collects such information for the primary purpose of providing quality health care. We require you to provide us with your medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs.
NAME:____

PREVIOUS MEDICAL HISTORY:
Please list any serious illnesses, operations or hospital admissions:

YEAR	DETAILS

Have you suffered from any of the following – currently or in the past? YES / NO
PLEASE CIRCLE RELEVANT CONDITIONS

Blood Pressure/Cholesterol	Schizophrenia / Bipolar
Diabetes/Thyroid	Heartburn / Acid reflux / Ulcer Bowel / Diverticulosis/ Polyps
Any type of Cancer	Stroke / epilepsy / Meningitis
Hepatitis B / Hepatitis C / HIV	Dementia / Pinched nerve
Asthma/ Pneumonia / Bronchitis	Leg clots / varicose veins
Emphysema / Blood Clot	Blocked blood vessel
Depression / Anxiety / Panic	Broken Bones / Fractures
Heart attack / Angina	Glaucoma / Cataract
Palpitations / Heart failure	Hearing Loss / Tinnitus / Vertigo
Arthritis / Osteporosis	Melanoma / Cysts
Rheumatoid arthritis	Acne / Dermatitis / Eczema
Menstrual Problems / Ovary infection	Erectile Dysfunction / Premature ejaculation / Cysts

FEMALE PATIENTS: WHEN WAS YOUR LAST **PAP SMEAR?** ____/______/_____ **MAMMOGRAM?** _____________

CURRENT MEDICATIONS – please list any tablets / injections or inhalers you are taking and if applicable include the "pill" and natural remedies. If you are not currently taking any medications please write NIL.

Medication	Dose if known

ALLERGIES – please list any allergies, in particular to medications. If you do not have any allergies please write NIL.

Allergies	Reaction

FAMILY HISTORY – Has anyone in your close family suffered from the following?

Disease	Who	What age	Disease	Who	What age
Heart Disease			Thyroid Disease		
High Blood Pressure			Osteoporosis		
Stroke			Cancer		
Blood Clots			Rheumatoid Arthritis		
Diabetes			Mental Illness		

SOCIAL HISTORY:

Marital Status: Single / Married / De-facto / Divorced / Widowed / Separated

	No. Per day	Year commenced	Year Quit	Type
Alcohol				
Smoker				