Forest Hill Family Clinic

249 Canterbury Road, Forest Hill VIC 3131

Telephone (03) 9875 6222 Facsimile (03) 9894 4867

Email: reception@foresthillclinic.com.au

NEW PATIENT REGISTRATION

If the patient is under 16 years of age, this form must be completed by a Parent/Guardian

Contact Details

Mr/Mrs/Ms/Miss/Master/Other (please circle)________

Gender: Male Female Transgender (please circle)

Patient Surname ________________________________

Patient First Name ______________________________

Date of Birth ___________________________________

Medicare Number ________________________________

Reference Number ______ Expiry Date ___________

Home Address __________________________________

Suburb _______________________ Postcode________

Home Telephone Number _________________________

Mobile Number __________________________________

Email Address ___________________________________

Patient Occupation _______________________________

If the patient is a child – name of Parent/Guardian:

Ethnicity of Patient________Country of Birth________

Do you need an Interpreter? Yes ☐ No ☐

Aboriginal or Torres Islander: Yes ☐ No ☐

Please circle if any of the following cards apply

Veterans Affairs/Pension Card Holder/Health Care Card

Card Number _______________________Expiry Date______

Emergency Contact/ Next of Kin Details

Name: ____

Relationship ____

Contact Number _____________________________________

The Clinic will contact you either by phone or text regarding recalls and reminders

Medication

Do you have any allergies or reactions to any Medications? If so, please provide details

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Do you take any regular medications (including puffers, contraception pill or any over-the-counter Medicines)? If yes, please provide details

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Medical History

Do you have a history of any significant illness, injury or operation? If yes, please provide details

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Do you have a family history of illness or allergy e.g. mother/father heart disease/diabetes? If yes, please provide details _____________________________

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Do you attend any Medical Specialists? _____________

Are you Vision Impaired? ___________________________

Are you Hearing Impaired? _________________________

(Complete below if over 15 years)
Smoking History – Non-smoker/Ex-smoker (please circle)

If a Smoker, how many per day ___________________

Do you drink Alcohol, if so how many glasses per day___?

Privacy Agreement and Patient Consent

FHFC needs to obtain your consent for messages to be left on your phone answering machine or message bank regarding matters involving your health. Your signature below indicates this and also that you understand FHFC complies with the Privacy Act (1988) and as part of the privacy policy they are committed to protecting the privacy of individuals and their personal information.

Signature: **Date:**