WMC
WEMBLEY MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Please fill out **both sides** of the form in capital letters

TITLE: _____ SURNAME: _____ GIVEN NAMES: _____

PREFERRED NAME: _____ DATE OF BIRTH: ____/____/____ MALE OR FEMALE

ARE YOU ABORIGINAL/ TORRES STRAIT ISLANDER? **YES / NO** CULTURAL IDENTITY _____
(i.e. Italian, Greek, French, Chinese, Irish etc)

BOTH PARENTS/LEGAL GUARDIANS NAMES: _____
(FOR PATIENTS UNDER THE AGE OF 16)

CONTACT DETAILS

HOME ADDRESS: _____

SUBURB: _____ POST CODE: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

Please tick preferred number for test results/surgery phone calls. HOME: ☐ WORK: ☐ MOBILE: ☐

Wembley Medical Centre uses SMS reminders for upcoming appointments and future recalls: OPT OUT

EMAIL: _____

Do you consent to the sending of your medical information via email? YES / NO

How did you find us? HotDoc: ☐ Online: ☐ Family and Friends: ☐ Other:_____

MEDICARE CARD HOLDERS

CARD NUMBER: ☐☐☐☐ ☐☐☐☐☐ ☐

Medicare Line Number (number before your name on Medicare card) ☐ Expiry Date: ☐/☐

PENSION NUMBER: _____ EXPIRY: ____/____/____
PENSION TYPE: Concession/ Health Care Card/ Commonwealth Seniors Card

DVA PATIENTS: CARD NUMBER: _____ Gold/White
CONDITION (if applicable) _____

NEXT OF KIN/ HEAD OF FAMILY FULL NAME: _____

DATE OF BIRTH: ____/____/____ RELATIONSHIP TO YOU: _____

CONTACT PHONE NUMBERS: _____

EMERGENCY CONTACT (If different to above)

FULL NAME: _____ RELATIONSHIP TO YOU: _____

CONTACT PHONE NUMBERS: _____

PLEASE READ AND SIGN THE BACK OF THIS FORM

IS YOUR VISIT FOR A MOTOR VEHICLE ACCIDENT OR WORK INJURY? YES - (*please complete details below*) / NO.

MOTOR VEHICLE ACCIDENT OR WORK INJURY INFORMATION

CLAIM NO:_____DATE OF INJURY____/____/____

EMPLOYER:_____INSURER:_____

ADDRESS:_____WORK NO:_____

FAMILY HISTORY (OF THE PATIENT)

Are your parents still alive? Mother: **YES/NO** Father: **YES/NO**

Has any member of your family been diagnosed with diabetes/ heart conditions/ breast cancer/ bowel cancer or any other form of cancer?

YES/NO

If yes, please provide illness and relationship to you:

_____

Are you: Child/ Married/ De facto/ Single/ Widowed/ Divorced Number of Children: _____

Do you drink alcohol? **YES/NO** How many days on average per week? _____

How many standard drinks per day? _____

Do you smoke? **YES/NO** If yes, how many per day/week? _____

Have you smoked previously? **YES/NO** When did you give up smoking? _____

CONSENT AND DECLARATION

I consent to Wembley Medical Centre collecting, using, storing and disposing of my personal information and releasing relevant information to other Health Professionals to allow quality medical care. In the case of workers compensation claims or pre-employment medical related consultations I consent to the release of relevant personal information to my employer, their authorized representatives and their insurers.

I consent to the inclusion on the Wembley Medical Centre recall reminder register.

I acknowledge I may receive correspondence by telephone, post, email or sms for follow up visits requested by the doctor, appointment reminders, medical updates and health information from Wembley Medical Centre.

I understand that all accounts must be paid at the time of the consultation.
I am responsible for all accounts of any children under the age of 16 years who I am listed as next of kin.

I have read and understood the Wembley Medical Centre Full Privacy Policy provided to me with this form.
I acknowledge that Wembley Medical Centre charges a fee for non-attendance and late cancellations of less than 2 hours notice.
I acknowledge that Wembley Medical Centre is a Private Billing Practice.

PATIENT OR PARENT/ GUARDIAN SIGNATURE: _____ DATE: ____/____/____