ELEANOR CLINIC

Patient Registration Form

SURNAME:	TITLE: MR ○ MRS ○ MSTR ○ MS ○ DR ○		
FIRST NAME:	DATE OF BIRTH:		
STREET ADDRESS:		PREFERRED PRONOUN:	
SUBURB:	POSTCODE:		
HOME PHONE:	WORK PHONE:		
MOBILE:	CONSENT TO RECEIVE SMS REMINDERS:	YES ○ NO ○	
	CONSENT TO LEAVE VOICE MESSAGES:	YES ○ NO ○	
MEDICARE NO: REF NO:		EXPIRY:	
PENSION NUMBER:		EXPIRY:	
DVA NO:	WHITE GOLD	EXPIRY:	
HEALTH CARE CARD NO:		EXPIRY:	
OCCUPATION:			

NEXT OF KIN:	RELATIONSHIP:	PHONE:
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE:
NAME & DATE OF BIRTH OF PERSON RESPONSIBLE FOR PAYMENT:		
MEDICARE CARD & REF NUMBER OF PERSON RESPONSIBLE FOR PAYMENT:		

Patient Background

To assist with health initiatives – Do you identify as belonging to any of the following groups:

Aboriginal ○ Torres Strait Islander ○ Aboriginal and Torres Strait Islander ○

I understand that Eleanor Clinic complies with the Privacy Act (1988) 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 Eleanor Clinic 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 advise of follow up visits, inclusion in the reminder systems, medical updates and health information and the release of relevant information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Eleanor Clinic to use and disclose my personal information (except when legal obligations must be met). I also consent to Eleanor Clinic using an integrated SMS system as a means of communication with me.	
Date:	**Patient/Guardian Signature:**

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Patient Medical Information

Patient Name: _____ DOB: _____

Address: _____

ALLERGIES:	*Please include medications, foods, tapes, etc..*
PAST MEDICAL HISTORY:	*Please include any previous illnesses, operations or procedures:*
FAMILY HISTORY:	◯Diabetes ◯Heart Disease ◯Depression/Anxiety ◯Stroke ◯Asthma ◯Breast Cancer ◯Bowel Cancer ◯Other type of cancer ◯High Blood Pressure *Please list condition & family member/s affected*: …… …… ……
CURRENT MEDICATION:	*Please include over the counter medications, this includes Panadol, Nurofen or any other pain medication, puffers, sprays & any natural remedies)*
SMOKER:	◯ Yes. If so, how many cigs per day _____ ◯ No ◯ Ex-Smoker and if so what year finished smoking _____
ALCOHOL:	◯ No ◯ Yes Drinks per day?_____ Days per week? _____
HEALTH SCREENING:	Date of last Cervical Screen (Pap Smear): _____ If over 50: ◯ Bowel Screen (Year_____), Mammogram: (Year)
DIET:	
EXERCISE:	Type:_____ How Often:_____
HEIGHT/WEIGHT	Height: _____ Weight: _____

Do you have anything else you would like to share with us that would help us look after you?

_____

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