Hamilton Family Practice
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Telephone : (03) 5572 5592 or (03) 5571 9277
Fax : (03) 5572 5348
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Hamilton Family Practice

PATIENT REGISTRATION & PRIVACY FORM

Surname:					
Given Name:					
Mr/Mrs/Ms/Miss/Mst		DOB		Occupation	
Medicare Card No:			Ref. No.		Expiry:
Pension/HCC No:			Expiry:		
DVA No			Type of Card:		Expiry:
Address:				Postcode	
Phone	H		W	M	
Are you willing to be contacted by	SMS	Y/N	Email:		
Country of Birth:					
Ethnicity:	***Are you Aboriginal or Torres Strait Islander (ATSI)?***				
	Are you of ATSI Origin / Non ATSI Origin?				
Allergies: Are you allergic or sensitive to any medications? Y/N? If so please list.					

Emergency Contact: In case of emergencies who should we contact? Please list all emergency contact numbers including Home (H), Work (W), Mobile (M) for your emergency contact.	Name: ..... Relationship: ..... Contact Nos: .....

Social History:		Family History			
Do you smoke? How many per day? Have you smoked previously? Quit Date?		*Married*	*Defacto*	*Single*	*N/A*
Drink Alcohol? How many per day/wk?		**Significant Medical conditions in your family:**			
Do you want to Quit any /all of the above?					

Confidential Past Medical History:	
Have you ever been a patient in a hospital? If so, for what reason?	
Are there any chronic disease/s you have suffered or currently suffer from?	
Do you take regular medication? Please list	

Privacy Agreement & Patient Consent:

I understand that Hamilton Family Practice and associated Medical Centres comply 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 Hamilton Family Practice 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 be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal 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 Hamilton Family Practice to use and disclose my personal information (except when legal obligations must be met).
I am aware and understand the administration fee structure. I consent to pay the annual administration fee to avail the services.

Patient's Signature:		Date:	Doctors Signature:

Please tell us how you have heard / known about us: *Friend* ☐ *Flyer* ☐ *News Paper* ☐ *Drive Past* ☐