

saratoga medical

NEW PATIENT REGISTRATION

<p>Title: _____</p> <p>Family name: _____</p> <p>Given name: _____</p> <p>Middle name: _____</p> <p>Preferred name: _____</p> <p>Date of birth: _____ Sex: M F</p> <p>Nationality: _____</p> <p>Address: _____</p> <p>Suburb: _____</p> <p>Postcode: _____</p> <p>Home phone: _____</p> <p>Work phone: _____</p> <p>Mobile: _____</p> <p>Email: _____</p> <p>Occupation: _____</p> <p>Consent to SMS: <input type="checkbox"/></p>	<p>Medicare No: _____ Ref: _____</p> <p>Expiry: _____</p> <p>Pension No: _____</p> <p>Expiry: _____</p> <p>Health Care: _____</p> <p>Expiry: _____</p> <p>DVA No: _____</p> <p>Expiry: _____</p> <p>Private health: _____ Ref: _____</p> <p>Expiry: _____</p> <p>Next of kin: _____</p> <p>Relationship: _____</p> <p>Phone: _____</p> <p>Emergency: _____</p> <p>Relationship: _____</p> <p>Phone: _____</p>
--	---

Name/Address/Phone no. of previous GP: _____

List any allergies: _____

Please list all current medications (including over the counter, herbal or other preparations, as well as prescribed).

Past operations or significant illness (if any): _____

Smoking status: please circle one: Smoker / Ex smoker / Non smoker

Family history of illness (eg. heart; BP; diabetes; stroke; arthritis; asthma; depression; other)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Last Tetanus injection: _____

Are you interested in receiving email newsletters and/or related information from this practice? YES NO

Follow us on Facebook @saratogamedical or Instagram @saratogamedicalcentre

We are interested to know how you heard about this surgery.

Referral from another patient Referral from other doctor other _____

PHOTO ID PROVIDED & SCANNED

YES NO

Consent

Please read the information on this form carefully. You are under no obligation to provide consent to the use of your personal information. In the event that you do not consent, we will respect your decision.

Please circle your answer and sign below.

- I give consent for the staff and doctors of Saratoga Medical to contact me on:
 Home phone..... YES NO
 Mobile phone..... YES NO
 If necessary leave a message on an answering machine (if I am unavailable)..... YES NO
- I understand that the doctors and staff may have to provide details of my ongoing care to third parties such as other healthcare providers (ie specialist, pathology). I understand the Australian Privacy Principles will be upheld at all times if my information is to be shared. I give consent for the doctors and staff of Saratoga Medical to collect and use my information as appropriate to ensure continuity of care. YES NO
- The Doctors at Saratoga Medical make every effort to provide expert medical care which may include referrals to specialists and/or allied health outside of this practice. I undertake to be responsible for my attendance at the consultations. If I am unable to attend I will notify the practice. I AGREE/I DISAGREE
- I agree to attend appointments that have been made (with the Doctors/Nurses) at Saratoga Medical and acknowledge that there may be a fee charged if I repeatedly fail to attend without 2 hours notification.

I have read, understand and agree to all the information on this form.

Name (print)

Relationship (self/guardian/parent)

Signature

Date

Due to the Privacy Act we need to know if at any time someone else may be collecting personal information for yourself ie: picking up prescriptions or referrals. Please list the name of any person & sign your authority to collect on your behalf and note that an appropriate form of identification (ID) will need to be produced by this person upon collection.

I _____ authorise _____
(Your name) (Person collecting information)

to collect personal information on my behalf.

This will remain valid until such time I notify the practice otherwise in writing.

Your signature: _____ Date: _____

