BRUNSWICK MEDICAL CENTRE
355 Sydney Road, Brunswick 3056
Tel: 03 9387 1661
Fax: 03 9387 1334

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Patient Registration & Privacy Form

Please circle:	Dr Mr Mrs Ms Miss Master					
First Name:						
Surname:						
Date of Birth:						
Address:						
Suburb:					Postcode	
Phone:	Home		Work		Mobile	

***Medicare Number:**_____ **Ref No:**_____ **Exp:** _____

***Health care card/Pension Card/Veteran Card Number:**_____ **Exp:**_____

***(Overseas Students Only) OSHC Full Name:**_____ **Membership No:**_____

***Private Patient: Full Name:**

Are you: Please Circle) Aboriginal Torres Strait Islander Aboriginal or Torres Strait Islander None

Allergies: Are you allergic or sensitive to any medications? ☐**No** ☐**Yes**
If yes Please list: **Specify reaction:**

Emergency Contact: (Relative/Friend)

In case of emergencies who should we contact? **Full Name: .....**
Please list all emergency contact number including **Relationship: .....**
Home (H), Work (W), Mobile (M) for your emergency contact. **Contact No: .....**

Social History:		**Family History (Please Circle)**
Do you smoke? How many per day/week?		**Single Married Defacto Separated Divorced Widow**
Have you smoked previously? Quit Date?		
Drink Alcohol? How many per week?		**Occupation:**
Recreational Drugs? How Often?		**Ethnicity:** **Country of Birth:**

Confidential Past Medical History:

Have you ever been a patient in a hospital? Most Recent (If so, for what reason? And where?)	☐**No** ☐**Yes- Please list**
Do you or has anyone in your family ever suffered from any of the following conditions? {Please Tick}	☐High Blood Pressure ☐Stroke ☐Heart Disease ☐Kidney Disease ☐Diabetes ☐Liver Disease ☐Depression ☐Stomach Problems ☐Asthma ☐Skin Disorders ☐Thyroid Disease ☐Cancer ☐Bleeding Disorders ☐Arthritis ☐Migraines ☐Alzheimer's ☐Anaphylaxis
Are there any chronic disease/s you have suffered or currently suffer from?	☐**No** ☐**Yes- Please list**
Are your Childhood immunisations up to date? ☐**No** ☐**Yes**	Do you take regular medication? ☐**No** ☐**Yes** --Please list

Privacy Agreement & Patient Consent:

I understand that Brunswick Medical Centre and associated Medical Centres comply with the privacy Act (1980) 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 Brunswick Medical Centre 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 Brunswick Medical Centre to use and disclose my personal information (except when legal obligations must be met).

Patient / Guardian Signature:_____ **Date:**____ **/**____**/**_____

Administration use
Receptionist initials: _____ **GP Signature:** _____