



Oxford Village Medical Centre & Skin Cancer Clinic

PATIENT DEMOGRAPHIC REGISTRATION FORM

| | | | |
|---|--|---|----------------|
| Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other_____ | Surname: | First Name: | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | Date of Birth: (DD/MM/YYYY) | Ethnicity: <input type="checkbox"/> Australian <input type="checkbox"/> Brazilian <input type="checkbox"/> British <input type="checkbox"/> Chinese <input type="checkbox"/> Colombian <input type="checkbox"/> Indian <input type="checkbox"/> Italian <input type="checkbox"/> Korean <input type="checkbox"/> Thai <input type="checkbox"/> Other:_____ | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | |
| Sexuality: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual | | | |
| Are you of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> No <input type="checkbox"/> Yes Aboriginal <input type="checkbox"/> Yes Torres Strait Islander <input type="checkbox"/> Both | | | |
| Medicare Number & Reference No. | # | Ref: | Expiry: |
| Do you have a Centrelink/Pensioner Concession/Seniors Healthcare Card? | <input type="checkbox"/> Yes <input type="checkbox"/> No | # | Expiry: |

| | | | |
|---|---|-----------------------|---------------------|
| Unit/Street Number/ Street Address | | | |
| Suburb | | Postcode | |
| Mobile Phone No. | | Home Phone No. | |
| Email Address | (PLEASE WRITE EMAIL IN CAPITAL LETTERS) | | |
| Next of Kin | | | |
| | First Name | Last Name | Relationship to you |
| | | | Contact Number |
| Emergency Contact | | | |
| <input type="checkbox"/> Same as Next of Kin | First Name | Last Name | Relationship to you |
| | | | Contact Number |

| | | | |
|--|--|---|--|
| ALLERGY: Do you have allergies to any medication? <input type="checkbox"/> Nil known <input type="checkbox"/> Yes. Please elaborate: | | | |
| MY HEALTH RECORD (MEDICARE CARD HOLDERS ONLY) MyHealthRecord allows allergies, significant conditions, medications and immunisation records accessible online by you and other Healthcare Providers. All IMMUNISATION RECORDS at this clinic will be uploaded to MyHealthRecord. Please tick 'No' if you DO NOT wish to have your IMMUNISATION RECORDS updated on MyHealthRecord <input type="checkbox"/> No | | RECALLS & REMINDER SYSTEM Our practice has a recall system in place for results that need to be followed up with an appointment. All results are discussed by the Doctor only. We also provide our patients with routine preventive care reminders e.g. follow up immunisations, annual skin checks and cervical screenings etc. Please tick 'No' if you DO NOT wish to have PREVENTATIVE CARE REMINDERS sent to you <input type="checkbox"/> No | |
| Significant Past/Active Medical Conditions: | | Family History – Any significant family history of illness & cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please elaborate on condition and relationship to you) | |
| Occupation: | Alcohol : <input type="checkbox"/> No. <input type="checkbox"/> Yes: ____ Days per week ____ Standard drinks per day | Tobacco : <input type="checkbox"/> No. <input type="checkbox"/> Ceased smoking <input type="checkbox"/> Yes: Cigarettes ____ per day | |

For each consultation, I offer to assign my right to Medicare benefits to the doctors of Oxford Village Medical Centre who will render the medical service(s). I understand it is necessary for this Practice to collect personal information from me for the purpose of health management and for associated administrative purposes. I consent to the Practice's Electronic Communication Policy and Privacy Policy on handling patient information. Both can be made available to me on request. I understand that failure to provide this Practice with all the information it needs may restrict its ability to provide the quality of health care that I want. I acknowledge that I have read and understood this form before signing it.

Signature: _____ **Date** ____/____/____