Oxford Village Medical Centre & Skin Cancer Clinic

PATIENT DEMOGRAPHIC REGISTRATION FORM

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other_____	**Surname:**	**First Name:**
Gender: ☐ Male ☐ Female ☐ Other	**Date of Birth:** (DD/MM/YYYY)	**Ethnicity:** ☐Australian ☐Brazilian ☐British ☐Chinese ☐Colombian ☐Indian ☐Italian ☐Korean ☐Thai ☐ Other:_____
Marital Status: ☐Single ☐Married ☐Defacto ☐Separated ☐Divorced ☐Widowed		
Sexuality: ☐ Heterosexual ☐ Homosexual ☐ Bisexual		
Are you of Aboriginal or Torres Strait Islander origin? ☐ No ☐ Yes Aboriginal ☐ Yes Torres Strait Islander ☐ Both		**Individual Healthcare Identifier (IHI) No. :**

Medicare Number & Reference No. :	**#**	**Ref:**	**Expiry:**
Do you have a Centrelink/Pensioner Concession/Seniors Healthcare Card?	☐Yes ☐ 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 ☐ Same as Next of Kin	First Name / Last Name / Relationship to you / Contact Number		

ALLERGY: Do you have allergies to any medication?
☐ Nil known ☐ 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 ☐**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 ☐**No**

Significant Past/Active Medical Conditions:	**Family History – Any significant family history of illness & cancer?** ☐ No ☐ Yes (Please elaborate on condition and relationship to you)	
Occupation:	**Alcohol** : ☐ No. ☐ Yes: ___ Days per week ___ Standard drinks per day	**Tobacco** : ☐ No. ☐ Ceased smoking ☐ Yes: Cigarettes ____ per day

For each consultation either by telehealth, telephone or in person, including but not limited to health assessments and management plans, I offer to assign my rights 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 ___/___/____