426 Princes Hwy, Narre Warren, 3805
Tel: (03) 9704 7244
Fax:(03) 9705 6322
Web: caseycityhealth.com.au

NEW PATIENT REGISTRATION FORM

Welcome to Casey Family Practice

To assist us in ensuring your personal information is correct, please complete the following details. Once completed, please hand this to the receptionist with your Medicare Card and Pension Card or Health Care Card if you have one.

We look forward to providing you with quality medical care.

NAME: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss .....

ADDRESS: .....

..... **POST CODE:** .....

DATE OF BIRTH: ...../...../..... ☐ MALE ☐ FEMALE

Do you identify as an ABORIGINAL OR TORRES STRAIGHT ISLANDER? ☐ YES ☐ NO

SMOKER: ☐ YES ☐ NO

HOME PHONE NO: ..... **MOBILE:** .....

WORK PHONE NO: ..... **OCCUPATION:** .....

EMERGENCY CONTACT: ..... **PHONE NUMBER:** .....

MEDICARE CARD NO: ..... **EXPIRY DATE:** ...../...../.....

PENSIONER CARD NO: .....

HEALTHCARE CARD NO: ..... **EXPIRY DATE:** ...../...../.....

VETERANS AFFAIRS CARD: ..... **TYPE:** ☐ GOLD ☐ WHITE ☐ ORANGE

ALLERGIES: .....

CURRENT MEDICATIONS: .....

.....

FAMILY HISTORY: .....

.....

PAST MEDICAL HISTORY: .....

.....

Email (if you like us to send news & information): .....

YOUR PRIVACY AND MEDICAL INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management. All information is de-identified. If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all times you health information is treated with utmost confidentiality.

❑ I have read and understood the above information regarding my medical information.

SIGNATURE OF PATIENT: ..... **DATE:** ...../...../.....

>**Dr Danh Lam** M.B.B.S., FRACGP, Provider No: 231172AA
>**Dr Steve Chau** M.B.B.S., M.Div, M.A, Provider No: 323379Y
>**Dr Richard Shawyer** M.B.B.S, MTH, Privider No: 031064BJ

QIP/AGPAL
SPECIALIST IN ACCREDITATION, QUALITY AND RISK MANAGEMENT