**New Patient Registration Form**

**Personal Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | | **Given name/s** | | | | | | | | | | **Preferred name** (if applicable) | | | | | | |
| **Surname** | | | | | | | | | | | | **Previous surname** (if applicable) | | | | | | |
| **Gender** | | | | **Sex** | | | | | | | | **Date of birth** | | | | | | |
| **Address** | | | | | | | | | | | | | | | | | | |
| **Suburb** | | | | | | | | | | | | **State** | | | | | **Postcode** | |
| **Phone #** | | | | | | | | | **Email address** | | | | | | | | | |
| **Marital status** | | | Single  | | | | Defacto  | | | | | | Married  | | Divorced  | | | Widowed  |
| **Do you identify as someone from a culturally and/or linguistically diverse background?** | | | | | | | | No  | | | | | Yes   Please elaborate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **To assist with health initiatives, are you of Aboriginal or Torres Strait Islander origin?** | | | | | | | | | | | | | | | | | | |
| No  | Aboriginal  | | | | | Torres Strait Islander  | | | | | | | | Aboriginal and Torres Strait Islander  | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Medicare card #** | | | | | | | | | | | | | | **Ref** | | **Expiry date** | | |
| **Do you have private health insurance?**  If NO, proceed to NEXT OF KIN section. | | | | | | | | | | | Yes  | | | | | No  | | |
| **Name of insurer** | | | | | | | | | | | | | | **Membership #** | | | | |
| **Are you aware of any exclusions in your private health insurance policy?** | | | | | | | | | | No  | | | Yes   Please elaborate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Next of Kin/**  **Emergency Contact** | | | | | **First name** | | | | | | | | | **Surname** | | | | |
| **Phone #** | | | | | | | | | **Relationship** | | | | |

**Account Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Who is responsible for your account today?**  If you selected SELF, please proceed to INTERESTED PARTIES section. | | | Self  | | | Other  |
|  | | | | | | |
| **Veteran Affairs (DVA)** | **Card colour**  Gold  White   Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Card number** | |
|  | | | | | | |
| **TAC Claims** | **Date of accident** | | | **Claim number** | | |
|  | | | | | | |
| **WorkCover Claims** | **Date of injury** | | | **Claim number** | | |
| **Insurance company** | | | | | | |
| **Case Manager** | | **Phone number** | | | | |
| **Employer name** | | **Employer address** | | | | |

**Interested Parties**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is your referring doctor your regular GP?** | | Yes  | | No  |
| **If NO, who is your regular GP?** | | | | |
| **Doctor’s name** | **Clinic name** | | | |
| **Do you have a usual physiotherapist?**  If NO, please proceed to the MEDICAL HISTORY section. | | Yes  | No  | |
| **Name** | **Clinic name** | | | |

**Medical History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Are you a smoker?** | | | Yes  | | No  |
| **Do you have any allergies?** | | | Yes  | | No  |
| If yes, please list your allergies | | | | | |
| **Have you ever had, or do you have any of the following?** | | | | | |
|  Asthma |  Heart attack | | |  Stroke | |
|  Epicardial pacemaker/wire |  Diabetes | | |  Pulmonary embolism | |
|  Deep vein thrombosis |  Bleeding tendency | | |  Rheumatic fever | |
|  Epilepsy |  Hepatitis | | |  High blood pressure | |
|  Contrast allergies |  Intracranial aneurysm clip | | |  Neurostimulator | |
|  Cochlear implant |  Metal implant/eye injury caused by metal | | | | |
|  | | | | | |
| **Do you take any anticoagulant medications?**  Please select all that apply. | |  Warfarin   Clopidogrel   Heparin   Clexane | |  Aspirin   Rivaroxaban   Apixaban   Ticagrelor | |
| **Please list your current medications** *(or provide a list with this document)* | | | | | |

**Privacy Consent**

As a patient of Clinical Precision, we require you to provide us with your personal health information so that we may properly assess, diagnose and treat medical conditions as required. Dr Steve Landers may also use de-identified images as part of his clinical research in microembolisation. For further information on the collection, use and disclosure of your health and photographic information, please refer to the privacy policy on our website at <https://www.clinicalprecision.com/privacy-policy>.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission for my personal health information to be collected, used and disclosed for the purposes outlined in Clinical Precision’s privacy policy. I understand that only my relevant personal health information will be collected, used and disclosed, and I am free to withdraw my consent at any time by notifying Clinical Precision in writing.

|  |  |
| --- | --- |
| Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |