Allegiance Medical
376 Centre Road
Bentleigh VIC 3204
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admin@allegiancemedical.com.au

Welcome to Allegiance Medical Centre
Our aim is to provide everyone with the best quality of health care
Please complete all sections carefully and read the Personal Information consent form attached

Title _____ Surname _____Given Names _____

Known as _____ Date of Birth _____/_____/_____ ☐ Male ☐ Female ☐ Non-Binary

Place of Birth ☐ Australia or ☐ _____ Another Ethnicity: _____

Are you from Aboriginal or Torres Strait Islander descent? Yes / No or Both

Address: _____

Suburb: _____State:_____ Postcode: _____

Phone: (Home) _____(Work) _____ (Mobile) _____

Email: (we may use this to contact you) _____

Medicare No: _____ Ref No: 1 2 3 4 5 6 7 8 Expiry Date: _____/_____

Concession Card: ☐ Pension ☐ Health Care Card ☐ Veterans Affairs

Card No: _____Exp. _____/_____/_____

Occupation: _____Employer_____

Emergency Contact (if same address, please write 'as above') *please write clearly*

Name:_____Relationship to you:_____

Address: _____Suburb_____Post Code_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Next of Kin (if same address, please write 'as above') *please write clearly*

Name:_____Relationship to you:_____

Address_____Suburb_____Post Code_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Have you any allergies? (including medications/drugs/environmental and dressings etc) Nil**:** □

FAMILY HISTORY

Father	□ Diabetes □ Depression □ Prostate Cancer	□ Migraine □ Poor Blood pressure	□ Heart disease/attack □ Stroke □ Asthma	□ Skin cancer □ Stomach Cancer Other? Please specify
Mother	□ Diabetes □ Depression □ Breast cancer	□ Migraine □ Poor blood pressure	□ Heart disease/attack □ Stroke □ Asthma	□ Skin cancer □ Stomach Cancer Other? Please specify

SOCIAL

Smoking	□ Non-Smoker	□ Ex-Smoker	□ Currently Smoking	Amount _____
Alcohol	□ Non-Drinker	□ Social Drinker	□ Moderate Drinker	□ Heavy Drinker
Exercise	□ Nil	□ Regular Exercise	□ Moderate Exercise	□ Elite Athlete

IMMUNISATIONS

Are Childhood Immunisations up to date? □ No □ Yes □ Unsure?

Do you have a yearly flu injection? □ No □ Yes

Date of last Tetanus Injection? _____ / _____ / _____

Date of last Pneumonia Injection? (over 65 yrs) _____ / _____

Before you register, do you consent to the following: Please circle

1. Our practice can provide patients with preventative care and early case detection reminders e.g. immunisations, skin checks, annual health checks, pap smears etc. Do you **CONSENT** or **NOT CONSENT** to being contacted with reminders? **YES** or **NO**
2. Do you CONSENT to being contacted as part of our recall system for following results? **YES** or **NO**
   Please note, if you circle NO, you are responsible for booking follow up appointments to obtain your test results
3. Do you **CONSENT** to being contacted/reminded of appointments via SMS? **YES** or **NO**

Patient name: _____

Signature of patient or Guardian: _____

Date: _____