Allegiance Medical
376 Centre Road
Bentleigh VIC 3204
Ph: (03) 8525 1480 Fax: (03) 9557 0988
admin@allegiancemedicalbentleigh.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

Title_____**Surname**_____**Given Names** _____

Preferred Name _____ **Date of Birth**_____/_____/_____ ☐ Male ☐ Female ☐ Other

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

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

Address: _____

Suburb:_____**State**:_____**Postcode**:_____

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

Email: _____

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._____/_____/_____

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**) _____

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

Name:_____**Relationship to you**:_____

Address:_____**Suburb:** _____ **Post Code** _____

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

Do you have any allergies? (including medication/drugs/environmental and/or dressings etc) Nil: ☐

CURRENT MEDICAL STATUS AND MEDICATIONS: _____

_____

FAMILY HISTORY				
□ **No significant Family History**				
Mother Alive □ Deceased □	Age of Death _____ Cause of Death _____	□ Diabetes □ Colon Cancer □ Hypertension □ Depression	□ Heart Disease □ Breast Cancer	□ Stroke
Father Alive □ Deceased □	Age of Death _____ Cause of Death _____	□ Diabetes □ Colon Cancer □ Hypertension □ Depression	□ Heart Disease □ Breast Cancer	□ Stroke

SOCIAL HISTORY			
Occupation:_____			
Smoking	□ Non-Smoker	□ Ex-Smoker □ Year Started _____ □ Year Stopped _____	□ Smoker Amount Per Day _____ *(Optional)*
Alcohol	□ Non-Drinker	□ Past-drinker □ Year Started _____ □ Year Stopped _____	□ Drinker Days Per Week __/ 7 Drinks Per Day ____

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, cervical screening tests etc. Do you **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**

Privacy Policy & Patient Consent – **Please see our website for more information: www.allegiancemedical.com.au .**

By signing below, you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information. I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained. I give my permission for my personal information to be collected, used and disclosed as described above (including contact via SMS to my mobile phone number). I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____