

MERENDA JUNCTION MEDICAL

Title: _____

Name: _____

Date Of Birth: _____ Email: _____

Patient Address: _____

Phone: _____ Mobile: _____ Gender: _____

Occupation: _____ Ethnicity / Nationality: _____

Medicare #: _____ IRN: _____ Expiry: _____

Are you of Aboriginal or Torres strait islander origin? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ De-facto

I permit Mernda Junction Medical to contact me via SMS ☐ Yes ☐ No

I permit Mernda Junction Medical to contact me via E-mail ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Details: _____ Work Phone: _____

NEXT OF KIN CONTACT

Name: _____ Relationship: _____

Contact Details: _____ Work Phone: _____

Do you hold any of the below cards? If so please provide details

<input type="checkbox"/> Centrelink Health Care Card	Card Number
<input type="checkbox"/> Centrelink Pension Card	_____
<input type="checkbox"/> Centrelink Senior Health Card	_____
<input type="checkbox"/> Dept. of Veteran Affairs (DVA) Gold Card	Expiry

I understand that Lakes Boulevard Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Lakes Boulevard Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits; inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Lakes Boulevard Medical to use and disclose my personal information (except when legal obligations must be met).

Patient / Guardian Signature: _____

How did you hear about us? ☐ Family ☐ Friend ☐ Google ☐ Hotdoc ☐ Health Engine
☐ Facebook ☐ Instagram ☐ Other: _____

Do you know about My Health Record? ☐ Yes ☐ No (If not, please ask our friendly reception staff)

Would you like our Clinical/Admin staff to register you for My Health Record ☐ Yes ☐ No
(Please ask a form to fill out from Reception)



HEALTH GROUP

Mernda Junction Shopping Centre,
Tenancy 11, 1435 Plenty Rd,
Mernda VIC 3754

P: (+61) 3 9088 4778
F: (+61) 3 9088 4779
mjmedical.com.au

NEW PATIENT REGISTRATION FORM (CHILD)

MERENDA JUNCTION MEDICAL

ONCE COMPLETED PLEASE HAND THIS FORM IN TO YOUR DOCTOR

Seen by Doctor

Scanned ☐

Patient Name: _____ Date Of Birth: _____

What medical concerns do you wish to discuss with your doctor today?

Past Medical History: Has your child suffered from any of the following – currently or previously, what year?

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Developmental Issues |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fractures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Bronchitis / | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bronchiolitis | |

Has your child had any operations or hospital admissions? ☐ Yes ☐ No

If Yes, Please provide details

Are your child's immunisations up to date? ☐ Yes ☐ No

If No, Please provide details

Medications and Social History: Please include ALL tablets, inhalers, patches, gels or injections – as well as any other "natural" remedies or supplements

MEDICATION

DOSE

FREQUENCY

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FAMILY HISTORY

MOTHER
ALIVE (Y/N)

FATHER
ALIVE (Y/N)

SIBLINGS

ALLERGIES

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis -
Osteoarthritis/Rheumatoid? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemochromatosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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The Information I have provided in this questionnaire is correct, complete and without any major omissions to the best of my knowledge.

Parent / Guardian Signature: _____ Date: _____