NEW PATIENT REGISTRATION FORM

The Stadium Clinic

We require this information to provide you with the best quality care.

Your personal health information is kept private and secure, as required by federal and state privacy laws.

If you have any concerns, please leave blank and discuss with your Specialist. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, allowing us to contact you promptly about tests and results.

THIS DOCUMENT IS DOUBLE-SIDED. PLEASE COMPLETE ALL PAGES WHEN REGISTERING

SECTION 1: PERSONAL INFORMATION

PLEASE WRITE YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD OR PASSPORT

Title: [ ] **Given Names** [ ]

Surname: [ ]

Preferred name: (if applicable) [ ]

Date of Birth [_____ / _____ /_____] **Birth Sex:** [M] [F]

Gender: [M] [F] **Other/Pronoun:** [ ]

Street Address:

_____

Town _____

State _____ Postcode _____

Occupation:

Phone:

(H) _____ (M)_____

Consent to SMS appt reminder: Yes / No

Email Address (Block Letters) _____

Medicare Number _ _ _ _ / _ _ _ _ _ / _ Position on Card: ____ Expiry ____/ ____

Parent details if patient under 16yo.

Name _____ **Date of Birth**_____/_____/_____

Medicare Number _ _ _ _ _ / _ _ _ _ _ / _ **Position on Card:** ____ Expiry ____/ ____

Pension, Health Care Card or Veteran's Affairs no. (if applicable)

_____ Expiry ____/_____

DVA CONDITONS: ALL or SPECIFIED:

Referring Doctor and Interested parties to receive relevant correspondence:

Referring Name & Address:

Family GP Name (if not referring Doctor): Practice Name & Address:

Physiotherapist Name: Practice Name & Address:

NEW PATIENT REGISTRATION FORM

We require this information to provide you with the best quality care.

Your personal health information is kept private and secure, as required by federal and state privacy laws.

If you have any concerns, please leave blank and discuss with your Specialist. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, allowing us to contact you promptly about tests and results.

THIS DOCUMENT IS DOUBLE-SIDED. PLEASE COMPLETE ALL PAGES WHEN REGISTERING

SECTION 2: CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Australian, non-indigenous ☐ Aboriginal but not Torres Strait Islander ☐

Torres Strait Islander but not Aboriginal ☐ Both Aboriginal and Torres Strait Islander ☐

Other Cultural Background: (e.g. Mediterranean, Asian, African, Pacifica) **Country of Birth**:

SECTION 3: MEDICATIONS AND ALLERGIES

Please list ANY Medications you are currently taking:

Medications:

Please list ANY Allergies that you have below:

Allergy/Reaction:

SECTION 4: PREVIOUS MEDICAL HISTORY

Do you have any illnesses? Please include any illnesses that you are not taking medication for:

Have you had any surgical procedures? Please include dates:

Are there any hereditary health conditions in your family? Please list:

SECTION 5: SPORTS & PHYSICAL ACTIVITY

If you take part in any Team Sport/ Activity or Regular exercise, please list below:

Sport/ Activity:

Times Per Week:

NEW PATIENT REGISTRATION FORM

We require this information to provide you with the best quality care.

Your personal health information is kept private and secure, as required by federal and state privacy laws.

If you have any concerns, please leave blank and discuss with your Specialist. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, allowing us to contact you promptly about tests and results.

THIS DOCUMENT IS DOUBLE-SIDED. PLEASE COMPLETE ALL PAGES WHEN REGISTERING

Section D: PERMISSION TO COLLECT AND STORE INFORMATION: Thank you for providing your personal health information to our practice. We undertake to manage this information in a secure manner and to use it only for the purpose of your health care or directly related purposes.

You have the right to access your medical record. You have the right to confidentiality. Information will not be disclosed without your prior consent, except in an emergency or where required by law, or for billing purposes (e.g. Medicare, or pathology provider).

Referrals to other health providers implies consent to disclose your personal health information.

By signing below, you are giving consent to The Stadium Clinic to hold and use your personal health information for these purposes.

I, _____ have read the above and agree to the collection and storage of my health information. (if your child is under 16 years of age, please sign on their behalf).

I authorise Dr_____ to release medical information to the referring doctor, insurance company, solicitor or other persons nominated by me.

Signed: _____ Date: _____

Acknowledgement of Country

The Stadium Clinic acknowledges the Gadigal people of the Eora Nation as the traditional custodians of the land on which we are fortunate to work and live, and recognise their continuing connection to land, water, and community.

Here in Moore Park, Sydney, we gather on Country on which members and Elders of the local Indigenous community and their ancestors have been custodians for many centuries and on which Aboriginal people have performed age-old ceremonies of celebration, initiation and renewal.

We acknowledge their living culture and their unique role in the life of the region.

We pay respect to Elders past, present and emerging.

Clinic Information:

The Stadium Clinic,

Byron Kennedy Hall, Building 15, Errol Flynn Blvd, Entertainment Quarter, Moore Park, 2021 Ph: 83236500
Fax: 83236555