THE DOCTORS AT LAVINGTON AND THURGOONA
NEW PATIENT REGISTRATION FORM 2025

CONTACT INFORMATION

Title (circle)	Mr / Mrs / Ms / Miss / Mast / Other_____		
First name		Preferred name	
Middle name		D.O.B	
Surname		Birth sex	
Gender identity (circle)	Female / Male / Non-binary / Transgender / Other_____		
Street Address			
Postal Address			
Phone	Home:	Mobile:	Work:
Email			

CULTURAL IDENTITY

Country of Birth	Australia ☐	Other _____	
Cultural Background			
Australian ☐	Aboriginal ☐	Torres Strait Islander ☐	Other (Chinese/Greek etc.) _____
Preferred Language		Interpreter required	☐ Yes ☐ No

HEALTH IDENTIFIERS

Medicare Number		Ref. Number		Exp.	
Pension/Health Care Card Number				Exp.	
DVA Card Number		DVA Colour (circle)		White / Gold	

NEXT OF KIN

Name			
Relationship		Contact	

EMERGENCY CONTACT

Name			
Relationship		Contact	

PATIENT CONSENT

Please read the below privacy statement and consent before carefully signing.

The Doctors at Lavington and Thurgoona collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used and disclosed and record your consent or restrictions to this consent. We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes to guarantee compliance with Medicare and the Health Insurance Commission requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- For the purpose of sending appointment reminders for scheduled appointments.
- Disclosure to others involved in your health care including treating doctors and specialists outside of this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure for statistical research and quality assurance activities to improve the individual and community health care and practice management. Please be advised that your personal details, such as your name, address and date of birth are withheld in these situations. Therefore, your identity is protected. You may elect for your information to be excluded in such activities.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by the court of law.
- To comply with any legislative or regulatory requirements ie: notifiable diseases.

I have read the information above and understand why my information must be collected and consent to the handling of my information by this practice and doctors supported by this practice.

I understand that I am not obligated to provide any information requested of me, but failure to do so may compromise the quality of healthcare and treatment given to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access my be legitimately withheld - in such circumstances I will be given an explanation.

I understand my doctor does not bulk bill and payment is required at the time of my appointment.

I understand that my doctor charges a failure to attend fee of $50-$100 if I fail to give the minimum notice of 2 hours to cancel or change my appointment.

I understand this practice and my doctor has a zero tolerance policy for any abusive or threatening behaviour and I will comply to this policy.

I understand that if I am prescribed opioid medications my doctor requires me to sign an 'opioid contract' to ensure I comply to the prescribing terms and attend regular appointments.

I consent to SMS text message appointment reminders to be sent to my mobile phone. ☐ Yes ☐ No

I consent to SMS text message recall reminders to be sent to my mobile phone. ☐ Yes ☐ No

I consent to the use of AI scribe tools during my consultations. ☐ Yes ☐ No

Patient Name	
Signature	
Name of Guardian (applicable)	
Date	

The DOCTORS at Lavington & Thurgoona

PATIENT MEDICAL INFORMATION

Patient Name:

PATIENT HISTORY

Please list your current medications (including over the counter or vitamin/herbal medications):

_____

_____

Please list any known allergies you have:

_____

Please list any operations/serious illnesses you have had:

_____

_____

Do you currently have or have you had a past history of any of the following medical conditions:

☐ Asthma	☐ Epilepsy	☐ Diabetes	☐ High Blood Pressure
☐ Heart Disease	☐ Stroke	☐ Colon Cancer	☐ Depression
☐ Psychiatric History	☐ Breast cancer	☐ Osteoporosis	☐ Cancer

Please list any other significant medical conditions not mentioned above:

_____

FAMILY HISTORY

Mother alive? ☐ Yes ☐ No Age at death:_____ Cause of death:_____

Did your mother have any of the following? (please circle):

Diabetes / High Blood Pressure / Heart Disease / Stroke / Colon Cancer / Depression / Breast Cancer

Other:_____

Father alive? ☐ Yes ☐ No Age at death:_____ Cause of death:_____

Did your father have any of the following? (please circle):

Diabetes / High Blood Pressure / Heart Disease / Stroke / Colon Cancer / Depression

Other:_____

SOCIAL HISTORY

Marital status (please circle): Single / Married / De facto / Separated / Divorced / Widowed

Sexuality: Asexual / Bisexual / Gay / Heterosexual / Homosexual / Lesbian / Other:_____

Are you an elite athlete? ☐ Yes ☐ No

Recreational activities you partake in:

_____

Accommodation: Own home / Rental / Other:_____

Live with: Spouse / Partner / Relative / Friend / Alone / Other:_____

Occupation:_____

Do you drink alcohol? ☐ Yes ☐ No Days per week:_____ Standard drinks per day:_____

Age when started drinking:_____ Age when stopped drinking:_____

Do you smoke? ☐ Yes ☐ No Cigarettes per day:_____

Age when started smoking:_____ Age when stopped smoking:_____