Wellness on Wellington New Patient enrolment form

Welcome to Wellness on Wellington. The doctors and staff at Wellness on Wellington are committed to providing you with quality care and service. We protect your privacy and treat all patient information, including health and financial details as private and confidential.

In addition to our professional and ethical obligations, our Practice handles your personal information in accordance with federal and state privacy law. This includes complying with the federal Australian Privacy Principles (APPs) forming part of the Privacy Act 1998 (Cth) and the Victorian Health Privacy Principles (HPPs) forming part of the Health Records Act 2001 (Vic).

Office use only	Chart Number	Entered	Scanned

Please fill in your name and details below as they appear on your Medicare card:

Title ☐ Given names ☐ Surname ☐

Date of birth ☐ Male ☐ Female ☐

Medicare card number ☐ Medicare card IN number ☐ Medicare card expiry date ☐☐/☐☐

Please tick if applicable: Pension ☐ Health Care card ☐ Veterans' Affairs ☐

Card number ☐ Expiry date ☐☐/☐☐/☐☐

Home Address ☐ Postcode ☐

Postal address : ☐ Occupation: ☐

home phone ☐ Work ☐ Mobile ☐ Email address: ☐

Do you consent to us contacting you on any of these numbers regarding your appointments or test results?

Yes ☐ No ☐

Who can we contact in case of emergency? ☐ Relationship to you: ☐

Home phone number ☐ Mobile ☐ Work ☐

Marital Status:

Single ☐ Married/ De facto ☐ Divorced ☐ Separated ☐ Widowed ☐

Knowing your cultural background can assist us to provide healthcare that meets your individual needs and access to appropriate Medicare packages.

Are you of Aboriginal or Torres Strait Islander origin?

NO ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Other cultural background: Eg. Mediterranean, Asian, African _____ Country of birth: _____

Is English your first language? Yes ☐ No ☐ If not, do you require an interpreter? Yes ☐ No ☐ Please specify language _____

How did you find out about us? Family attends ☐ Friend / Neighbour ☐

Yellow page s ☐ Website ☐ Signage ☐

Why have you not attended your previous medical practice today:

Unable to get an appointment at my regular practice ☐ Recently moved to the area ☐

Unhappy with the service provided at previous practice ☐ Other ☐

If you are dissatisfied with the service provided at your previous health center please identify your main area of concern: _____

Please indicate what type of household best describes your circumstances:

Couple with children ☐ Single parent family ☐ Live alone ☐

Couple without children ☐ Group household ☐ Other ☐

Would you be happy to receive a short follow up questionnaire regarding your visit with us today?

Yes ☐ No ☐

Please be aware that we are a **privately billing practice**.

We bulk bill eligible pension card holders and children under16 years of age **only** for consultations between 8.00am and 6.00pm on weekdays. Discounted fees apply for these patients after 6.00 p.m. on weekends and on Public Holidays. Fees apply for **ALL** patients for procedures such as stitches, fractures, removal of foreign bodies etc.

A fee schedule and a copy of our Privacy Policy are available at reception and are also displayed on the waiting room noticeboard.

CONSENT:

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, telephone or SMS for procedures such as vaccinations, pap smears and other health reviews.

I consent to being contacted for reminders to help me maintain my health: YES ☐ NO ☐

Signature of patient or guardian: _____ Date _____

Please take this completed form and your current Medicare card to our receptionists.