



MMC
MATRAVILLE MEDICAL COMPLEX
REGISTRATION FORM

(Welcome to the centre, please complete ALL the following details)

Medicare Card Number:		Ref No.	Expiry Date:		
Do you have a Pension Card or Health Care Card? <input type="checkbox"/> Pension Card <input type="checkbox"/> Health Care Card					
Patient's first name:			Patient's last name:		
<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Married / Divorced / Separated / De Facto / Widowed	Birth date:	Age:	Sex:
<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.		/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street address:					
City:			State:	Post Code:	
Occupation:		Employer:	Employer phone no.: ()		
Home phone no: ()		Work phone no: ()	Mobile no:		
Your email address:					
Are you a Torres Straight islander, or Aboriginal? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Contact in cases of emergencies:					

Name?	Phone Number?
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Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which ones?
Please List you current Medications:	

Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many per day?
Do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Every Week <input type="checkbox"/> Every Day	

PATIENT AGREEMENT

I do hereby consent for my medical information and test results to be sent to another doctor, specialist, solicitor or insurance company, if requested. I also consent for staff at Matraville Medical Complex to request and receive medical information and test results (if applicable) on my behalf.

Patient/Guardian signature

Date

If this consultation is
 due to an injury at work (workers compensation)
 a travel consultation
 a cosmetic consultation
then please ask for a further form to complete.

If you want more information on the services we provide, please ask reception for a patient information booklet.

Our privacy policy is on display. If you wish a copy, please ask at reception.

Thank you for completing this form, we hope that the wait for the doctor will not take too long.

PRE – TRAVEL ASSESSMENT FORM

(First page only to be completed by traveler)

Place Sticker Here

Date Today:		Date of Departure:		Date of Return:	
Country (in order of visit)		Which cities?		Accommodation (hotel / tent / backpack)	

Is your general health good? Yes No

Could you be pregnant while away? Yes No

Will children be travelling with you? Yes No

Are you allergic to eggs, medications or other substances? Yes (If yes, please list below) No

Please list past medical /health problems you have had both here and overseas and especially note past history of **jaundice, hepatitis, ear or hearing problems or have a disease which lowers immunity (e.g. cancer, HIV/AIDS):**

Please indicate the most recent year, the following vaccines were given to you:

<u>Vaccine</u>	<u>Year given</u>	<u>Vaccine</u>	<u>Year given</u>	<u>Vaccine</u>	<u>Year given</u>
Tetanus/diphtheria		Typhoid		Mantoux/BCG – not at MMC	
Polio		Cholera		Meningitis	
Flu vaccine		Hepatitis A		Japanese Encephalitis	
Pneumovax		Hepatitis B		Q fever – not given at MMC	
Measles/Mumps/Rubella		Combined Hep A and B		Rabies	
Varicella		Combined Hep A and Typhoid		Yellow fever	

Would you like information on medical kits for travelers to prevent illness? Yes No

How will you be paying? Cash Credit Card (what is your credit card type?)

The staff will print out a TRAVAX report on your destination countries for you to read while you wait.