Patient Registration Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by providing your patient details, including family history and consents.

PERSONAL INFORMATION

Title: _____ Date of birth: _____

Birth Sex: MALE / FEMALE Gender (*if different to sex*): _____

Surname: _____ First name: _____

Preferred name: _____ Preferred pronouns: HE/HIM SHE/HER THEY/THEM

Street address: _____

Suburb: _____ Postcode: _____

Postal address (*if different to above*): _____

Home phone: _____ Mobile phone: _____

Email: _____ Work phone: _____

Ethnicity/Country of birth: _____ Occupation: _____

Marital status: Please circle one of the following options

Single Partnered Married Separated Divorced Widowed

REASON FOR REGISTERING AT THIS PRACTICE

Looking for a new regular doctor ◯ Recently moved to the area ◯

Unable to get an appointment at my usual doctors practice ◯

Other _____

NEXT OF KIN

Name: _____ Relationship to you: _____

Home Phone: _____ Mobile Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Home Phone: _____ Mobile Phone: _____

HEALTHCARE IDENTIFIERS

Medicare Number:_____ Ref: _____ Expiry: _____

Dept. of Veterans' Affairs File Number: _____ ◯ Gold ◯ White

Concession Card type:_____ Card Number: _____ Expiry: ___/___/_____

CULTURAL IDENTITY

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?
◯ No ◯ Yes – Aboriginal ◯ Yes - Torres Strait Islander ◯ Yes - Aboriginal & Torres Strait Islander

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures -
Do you identify as someone from a culturally and/or linguistic diverse background? ◯ No ◯ Yes
Please elaborate _____
If yes, do you require an interpreter service? ◯ No ◯ Yes

ARE YOU: A REFUGEE ◯ AN ASYLUM SEEKER ◯ MONTH/YEAR OF ARRIVAL: _____ /_____
If you are a refugee or asylum seeker, who is your case worker? Name: _____ Phone: _____

YOUR HEALTH INFORMATION

ALLERGY INFORMATION

Do you have any allergies or are you sensitive to drugs or dressings? ◯ No ◯ Yes – provide details:

_____

CURRENT MEDICATIONS

Please list all your current medications, including complementary and over-the-counter medicines (*e.g. Homeopathic medicines such as vitamins and minerals etc.*)

_____

_____

MEDICAL HISTORY

Have you ever had?

◯ Surgery (provide details):			
◯ Chronic Illness (provide details):			
◯ Diabetes	◯ High blood pressure	◯ Asthma	◯ Heart disease
◯ Other (provide details):			

LIFESTYLE RISK FACTOR INFORMATION

Smoking

◯ Non smoker (never smoked)	◯ Ex Smoker - Date stopped___/_____	◯ Current smoker: _____/day

Alcohol

◯ Non drinker	◯ Drinker: How many - ___ per day / ___ per week / ___ per month

Recreational Drug Use

◯ Non user	◯ Yes: Type _____ Frequency: _____

FAMILY HEALTH HISTORY INFORMATION

Nil significant family history: ◯	Family history unknown (eg adopted): ◯

MOTHER: Alive ◯ / age at time of death? _____ Cause of death?

Does/did your mother have a history of any of the following:

◯ Diabetes ◯ High Blood pressure ◯ Heart Disease ◯ Stroke

◯ Asthma ◯ Mental Illness ◯ Cancer (specify):

FATHER: Alive ◯ / age at time of death? _____ Cause of death?

Does/did your father have a history of any of the following:

◯ Diabetes ◯ High Blood pressure ◯ Heart Disease ◯ Stroke

◯ Asthma ◯ Mental Illness ◯ Cancer (specify):

OTHER FAMILY: Do you know of any other family with these conditions? Please write which family member (Grandparent on Mum or Dads side/uncle/brother etc):

◯ Heart Disease ◯ Asthma ◯ Diabetes

◯ High Blood pressure ◯ Mental Illness ◯ Cancer (specify):

PATIENT CONSENT

Please read this consent form carefully prior to signing.

This general practice 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 or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, often issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this

medical 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.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important, and we will take all steps necessary to ensure they remain confidential.
Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy, and disclosure of your patient information.

I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I give permission for my personal information to be collected, used, and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Please note: email is not a secure method of communication. We advise all patients not to email us with personal information.

Patient name: (please print) _____

Signature: _____ Date: ____/____/_____

If not patient signing - Your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:
Witnessed by: (staff signature) _____