NEW PATIENT REGISTRATION FORM

Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Mast ☐ Other _____

Please circle: Male / Female

Family Name _____

Given Name/s _____

Preferred Name _____

Date of Birth __ __ / __ __ / __ __ __ __

Home Address

_____

_____

Postal Address (if different to home address)

_____

_____

Home Number _____

Work Number _____

Mobile Number _____

Email _____

Do you consent to receive SMS reminders? Yes / No

Medicare Number __ __ __ __ __ __ __ __ __ __ Ref: __

Expiry Date: __ __ / __ __ __ __

Veterans' White / Gold _____ Expiry _____

HCC/Pension _____ Expiry _____

Do you identify as: Non-indigenous ☐ Aboriginal ☐

Torres Strait Islander ☐ Both ☐

Next of Kin Name _____

Relationship _____

Contact Number _____

Emergency Contact Name _____

Relationship _____

Contact Number _____

Previous Doctor Name _____

Address _____

_____

Phone number _____

Do you need to transfer your medical records? Yes / No

Nationality _____

Cultural Background _____

Do you need an interpreter? Yes / No

Languages Spoken _____

Occupation _____

If the patient is a child, name of parent/guardian:

_____

Marital Status: Single / Married / Defacto / Separated / Divorced / Widowed

Do you have any known **ALLERGIES** food/medication? If yes, please give details.

_____

_____

Do you take any regular medications? (inc. the pill and over the counter medications) If yes, please give details.

_____

_____

Do you have a history of any significant illness, injury, operations or accidents? If yes, please give details.

_____

_____

Do you have any family history of illness or allergies? (Mother – Diabetes, Father – Heart Disease)

_____

_____

Do you smoke? Yes / No _____ per day

Do you drink alcohol? If yes, how many glasses on average would you drink in a day? _____ glasses

Do you wear glasses/contact lenses? Yes / No

Do you have hearing difficulties? Yes / No

3rd Party Signed Authorisation

(Person who can act on your behalf)

Name _____ DOB _____

Relationship_____

Recallsand Reminders

SMS Notification – Tick to Opt OUT ☐

eHealth

My Health Record Consent to Upload ☐ Yes ☐ No

Declaration

I agree that all the information I have provided is true and correct to the best of my knowledge.

Signature _____ Date _____

PATIENT CONSENT - HEALTH INFORMATION COLLECTION, USE AND DISCLOSURE

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, frequently 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.

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.

Patient Surname | First Name

Signature of Patient / Guardian | Date

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

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