



# NEW PATIENT REGISTRATION FORM

Title: \_\_\_\_\_ Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender at birth:  Male  Female Gender Identity: \_\_\_\_\_

Do you identify as any of the following:

Please Tick:  Heterosexual  Gay  Lesbian  Bisexual  Transgender  Intersex Other: \_\_\_\_\_

(Only complete this question if you are aged 15 and over)

Phone: Mobile: \_\_\_\_\_

Phone: Work: \_\_\_\_\_

Knowing your cultural background can help us provide health care that meets your individual needs

Do you identify as any of the following:

Please tick:  Aboriginal  Torres Strait Islander  Aboriginal and Torres Strait Islander  Neither

If yes, have you previously registered for closing the gap?  Yes  No

Medicare Number: \_\_\_\_\_ Ref No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Please tick:  Pension Card  Veterans Affairs Card  Health Care Card  Commonwealth Seniors Card

Private Health:  Yes  No If Yes:  Basic  Intermediate  Top

Concession Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Type of Veterans Affairs Card: \_\_\_\_\_

MyMedicare Registered:  Yes  No Regular Practitioner: \_\_\_\_\_

Residential Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Postal/P. O (if not same as above) \_\_\_\_\_ Postcode: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  De Facto  Separated

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Consent to receive communication via email-text:  Email  Text

Country of birth: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Do you need an interpreter:  No  Yes If yes, please specify language: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone number: \_\_\_\_\_

Emergency contact: As above/Other: Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



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Allergies:  No  Yes: Item, Nature of reaction, Severity: \_\_\_\_\_

Do you have or ever had:

Condition	Yes	Date of diagnosis	Condition	Yes	Date of diagnosis
Arthritis			Heart attack		
Asthma			High blood pressure		
COPD/Emphysema			High cholesterol		
Bowel condition			Kidney, bladder or urinary problems		
Epilepsy			Hearing		
Diabetes			Vision		
Cancer-please specify			Any other long-term condition please specify		

Please list any surgical operations and the date if known.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any medications you are currently taking and their dose, include any alternative medicine or over the counter e.g. Mylanta, vitamin's.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How often do you have a drink containing alcohol.

Never  Monthly or Less  2-4 times a month  2-3 times a week  4or more times a week

How many standard drinks containing alcohol do you have on a typical day.

1 or 2  3 or 4  5 or 6  7 to 9  10 or more

How often do you have 6 or more drinks on one occasion.

Never  Less than monthly  Monthly  Weekly  Daily or almost daily

Smoking:  Non-smoker  Ex smoker (Quit date): \_\_\_\_\_  Smoker: Number per day: \_\_\_\_\_

Year Commenced: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Have any of you mother, father, siblings or grandparents ever suffered from:

Heart disease		Diabetes	
Asthma		Prostate cancer	
Bowel cancer		breast cancer	
Skin cancer/melanoma		Epilepsy	
Stroke		Depression and/or mental health illness	
Other please specify			

Have you ever served in the Australian defence force? If yes, please specify: \_\_\_\_\_

Please list any sports or hobbies you take part in: \_\_\_\_\_



# HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referrals to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually, information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

**I have read the information above and understand the reasons why my information must be collected.**



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



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



**I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.**



**I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.**



**I understand that while efforts are made to maintain confidentiality, there are associated risks communicating via email**



**I understand that I may withdraw my consent to communicate via email at any time and will notify the practice of any changes to my details.**



Patients Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patients Signature: \_\_\_\_\_ Signed as Guardian for child: \_\_\_\_\_