# *NEW PATIENT REGISTRATION FORM*

**Title:** _____ **Name:** _____ **Surname:** _____

**Preferred Name:** _____ **Date of Birth:** ___/____/_____ **Male/Female**

**Medicare Number** __ __ __ __ - __ __ __ __ __ - __ **Ref No** __ **Expiry Date** ___/_____

**(Please circle):** Aboriginal/ Torres Strait Islander / Aboriginal & Torres Strait Islander / Neither Aboriginal nor TS

**(Please circle):** Pension Card / Veterans Affair Card / Health Care Card / Commonwealth Seniors Card

**Concession Card Number:** _____ **Expiry Date** ____/____/_____

**Private Health Cover:** (please circle) Yes/No – If yes (please circle) Basic / Intermediate / Top

**Residential Address**: _____
No. Street Name Suburb/City Postcode

**Postal Address / P.O Box (if not the same as above)** _____

**Phone Number: Home:** _____**Work:** _____ **Mobile:** _____

**Marital Status: (please circle):** Single / Married / Widowed / Divorced / Defacto / Separated

**Occupation:** _____ **Email Address:** _____

**Country of Birth: Australia / Other:** _____ **Ethnicity:** _____

**Next of Kin:** Name: _____ Relationship to Patient: _____

Home Phone Number: _____ Mobile Number: _____

**Emergency Contact Person:** as above / other: Name: _____

Relationship to Patient: _____ Phone Numbers: _____

**Allergies: (please circle**) Nil known / Yes – Item, Nature of Reaction, Severity: _____

_____

**Asthmatic: (Please circle):** Yes / No **Diabetic: (please circle):** Yes / No

List any ongoing issue the patient may have: _____

**Alcohol Intake:** Non-drinker / Days per week _____ Standard drinks per day _____

**How often do you have 6 or more drinks on one occasion? (please circle):**

Never / Weekly / Monthly / Less Than Monthly / Daily or Mostly

**Smoking: (please circle):**

Non-smoker / Ex-smoker / (Quit Date: _____) / Smoker (if yes – no. per day_____)

**Weight:** _____kg **Height:** _____cm

Do you take medication?
Please list:

Complimentary therapies:
Please list: (see note below)

Note: Complimentary therapies include but are not limited to: Chinese medicine, Meditation, Prayer, Herbal, Vitamins, Supplements, Chiropractic, Reiki, Qi Gong etc.

Social History (recreational drugs or over the counter):

Past Medical History:

Past Surgical History:

Past Family History:

Have you ever been in the Australian Defence Force? If yes please specify:

Please list any sports or hobbies you take part in:

## HAVE YOU JOINED E-HEALTH?

WHAT IS E-HEALTH?- E-Health is an electronic health record, enabling the sharing of patient data between healthcare professionals nation-wide.

WHAT IS THE BENEFIT OF JOINING E-HEALTH?- The main benefit of joining E-Health is efficient treatment in emergency situations e.g. If you are involved in a car accident interstate, ED medics can quickly access your medical history, using your date of birth, licence etc.

HOW DO I REGISTER MYSELF AND FAMILY?- It's as easy as giving us your consent by filling out the information below.

FULL NAME:_____
DATE OF BIRTH:_____
MOBILE NUMBER OR EMAILM ADDRESS:_____
SIGNATURE OF CONSENT:_____

Once registered you will receive a notification on your mobile or email address. Any questions please speak to one of our friendly staff.

# 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 though referral 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 eg 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.** | ☐ |
| **OR** | |
| **I am unsure and would like to discuss this further with someone from the medical practice before I sign.** | ☐ |

Patients Name_____ Date_____/_____/_____

Patient's signature_____

Signed as Guardian for child_____ Name (printed) _____