Medical Matters

PATIENT REGISTRATION FORM

Title: _____ First Name: _____ Middle Initial(s): _____ Surname: _____

Date of Birth: _____/_____/_____ Address: _____

_____ State: _____ Postcode: _____Country of Birth_____

Email: _____ Occupation: _____

Mobile Phone: _____ Consent to receive SMS reminders: YES ☐ NO ☐

Home Phone: _____ Work Phone: _____

*Do you identify as being of *Aboriginal origin*: ☐ *Torres Strait Islander origin*: ☐ *or both?* ☐

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Line Ref: ___ Expiry: _____ / 20_____

Concession Card? PENSION ☐ HEALTHCARE ☐ No: __ __ __ __ __ __ __ __ __ __ Expiry: ___ /___ /20____

DVA card? GOLD ☐ WHITE ☐ No: _____ Expiry: ___ /___ /20____

Next of Kin Name & Relation (mother/father etc): _____ Tel: _____

Emergency Contact Name (if different from above): _____ Tel: _____

CURRENT MEDICATIONS:

_____

PREVIOUS MEDICAL HISTORY / OTHER IMPORTANT INFORMATION:
Please list any significant previous health issues (eg: diabetes, heart condition etc) _____

_____

Have any immediate family members *(mother, father, brothers or sisters)* suffered from:

Diabetes ☐ Heart Disease ☐ Asthma ☐ Stroke ☐ Cancer ☐

If yes to Cancer, which type? _____

What is your height? _____ and weight? _____

Allergies to Prescription Drugs / Food? NO ☐ YES ☐ Details: _____

Almost done….PLEASE TURN OVER

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Do you smoke? NO ☐ YES ☐ How many on average per day? _____ If recently stopped, when? _____

Alcohol Use? NO ☐ YES ☐ How many standard drinks on average per week? _____

Non-Prescription Drug Use? NO ☐ YES ☐ Type and frequency of use: _____

WOMEN ONLY
Are you pregnant? NO ☐ YES ☐ How many weeks? _____

When was your last Pap smear? _____

Patient Acknowledgement - COLLECTION OF PERSONAL INFORMATION, PRIVACY ACT 1988

This medical 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 be pro-active in your health care. We will also use the information you provide in the following ways:

- Administrative purposes in running our practice (e.g. vaccination reminders, appointment reminders etc.)
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- 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. If necessary, we will discuss this with you.
- Disclosure in emergency situations where medical officers / hospitals require access for treatment.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

I understand the reasons why my information is being collected and that this practice has a privacy policy on handling patient information. I understand that I'm not obliged to provide any information requested of me, but that failure to do so might compromise the quality of the health care and treatment given. I understand that I can request any medical information held about me at any time and I accept that a small admin fee may be payable to obtain such information.

Patient Signature ***(or parent/guardian if patient under 18):*** _____ Date: _____ /_____/_____

By further ticking the box below, you consent for your details to be used to inform you of important practice information and new services via various communication methods. It will never be used by third parties for marketing purposes or sold, and you will always be given the opportunity to opt-out. ☐

Office Use Only: Entered By_____