

PATIENT REGISTRATION FORM

Title (please circle) Dr/ Mr./ Mrs./ Ms./ Miss/Mstr/Rev/Sir	First Name:	Surname:	
Preferred Name:		DOB:	
Street Address:		Suburb:	Postcode:
Mobile Phone Number:	Home Phone Number:	Work Phone Number:	
Email Address:		Occupation:	
Postal Address (if different from above):			
Medicare Care Card Number	Ref No.	Expiry:	
Pension Card/Health Care Card Number		Expiry	
DVA Card Number	DVA Card Type: Gold <input type="checkbox"/> (Full DVA) White <input type="checkbox"/> Conditions: _____		
Do you have any ALLERGIES or are you sensitive to drugs or dressings: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please list details) _____			
Smoker: YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, how many cigarettes per day?		
Alcohol: YES <input type="checkbox"/> NO <input type="checkbox"/>	If yes, how many glasses per day?		
Height (cm)	Waist (cm)	Weight (kg)	
Drug Use : YES <input type="checkbox"/> NO <input type="checkbox"/>	If Yes: Type		Frequency:
Do you have an ADVANCED HEALTH DIRECTIVE? YES <input type="checkbox"/> NO <input type="checkbox"/>		Do you have an ENDURING POWER OF ATTORNEY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Do you identify as someone from a culturally and/or linguistically diverse background? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES – please elaborate _____			
To assist with health initiatives, are you Aboriginal or Torres Strait Islander? YES <input type="checkbox"/> NO <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Do not wish to answer <input type="checkbox"/>			
Our practice uses a reminder system to maintain your health record. The practice sends reminders and recalls via SMS, POST and TELEPHONE. By becoming a patient of this practice you are automatically consenting to the above mentioned procedure.			

Do you have any previous illness or medical condition we need to be aware of (tick below)

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Valve Surgery |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Skin cancer surgery | <input type="checkbox"/> Other health Issues – |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins | provide relevant details: |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Deep vein thrombosis | _____ |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> currently pregnant | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV | _____ |
| | | _____ |

Emergency Contact		Next of Kin	
Full Name		Full Name	
Relationship to you		Relationship to you	
Home Phone Number	Mobile Phone Number	Home Phone Number	Mobile Phone Number

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- For use when seeking treatment by other doctors in this practice.
- **For third party consent to obtain results of pathology/imaging/x-rays/specialist letters on your behalf, if yes please write the name & DOB of the third party Name _____ DOB _____**

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, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.
 I agree to assign my right to benefits to the provider who rendered the services.
 Patient (please print): _____
 Signature: _____ Date: _____
 If not the Patient signing – Your name (please print): _____

How did you hear about us? Word of mouth Website Signage Social Media Other: _____