INTEGRATED MEDICAL SOLUTIONS GROUP

NEW PATIENT REGISTRATION FORM

Title 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 Number		**Expiry**
Health Care Card Number		**Expiry**

DVA Card Number
DVA Card Type: Gold ☐ (Full DVA) White ☐
Conditions:____

Do you have any ALLERGIES YES ☐ NO ☐

If yes, please list details and reactions if any______________________________

Are you sensitive to drugs or dressings YES ☐ NO ☐

Smoker: YES ☐ NO ☐	**If yes, how many cigarettes per day?**	
Alcohol: YES ☐ NO ☐	**If yes, how many glasses per day?**	
Height (cm)	**Waist (cm)**	**Weight (kg)**
Drug Use : YES ☐ NO ☐	**If Yes: Type**	**Frequency:**

Do you have an ADVANCED HEALTH DIRECTIVE? **YES ☐ NO ☐**	**Do you have an ENDURING POWER OF ATTORNEY?** **YES ☐ NO ☐**

Do you identify as someone from a culturally and/or linguistically diverse background?

NO ☐ YES ☐ please elaborate ____

To assist with health initiatives, are you Aboriginal or Torres Strait Islander? YES ☐ NO ☐

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.

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

____

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

☐ **High blood pressure**
☐ **Angina**
☐ **Diabetes**
☐ **Bleeding tendency**
☐**Stomach Ulcer**
☐ **Asthma**

☐ **Hepatitis**
☐**Skin cancer surgery**
☐ **Varicose Veins**
☐ **Deep vein thrombosis**
☐ **currently pregnant**
☐ **HIV**

☐ **Heart Valve Surgery**
☐ **Other health Issues –**
provide relevant details:

____

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____

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Next of Kin		Emergency Contact	
Full Name		**Full Name**	
Relationship to you		**Relationship to you**	
Phone Number		**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 collect may be acquired by a number of different methods - examples may include: medical test results, notes from 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 or 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):