INTEGRATED MEDICAL SOLUTIONS GROUP

Wamuran Doctors
1100 D'Aguilar Hwy
Wamuran QLD 4512
P 07 5496 6399

Woodford Doctors
71-75 Archer St
Woodford QLD 4514
P 07 5422 9399

Doctors at Morayfield
70 Michael Ave
Morayfield QLD 4506
P 07 5495 5400

Doctors at Eatons Hill
1 Queen Elizabeth Dr
Eatons Hill QLD 4037
P 07 3325 5999

Doctors at Landsborough
Shop 2, 40 Cribb Street
Landsborough QLD 4550
P 07 5360 9350

PATIENT REGISTRATION FORM

Title (please circle) Dr/ Mr./ Mrs./ Ms./ Miss/Mstr/Rev/Sir	**First Name**:	**Surname**:
Preferred Name:	**DOB**:	**Gender**: Male ☐ Female ☐ Other ☐ _____ Do not wish to answer ☐
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 /Senior Concession Card Number:		**Expiry:**
DVA Card/Pension Card Number:	**DVA Card Type: Gold ☐ (Full DVA) White ☐ Conditions:**_____	

Do you have any ALLERGIES or sensitivity to any medications or dressings: ☐ Yes ☐ No

(if yes, please list all details) _____

Are you a Smoker: YES ☐ NO ☐ Ex-Smoker ☐ Year Quit:_____ Ex-Heavy Smoker ☐ Ex-Light Smoker ☐

If yes, how many cigarettes per day do you smoke? 1- 5 ☐ 5-10 ☐ 10+ ☐ Other:_____

Do you Drink Alcohol: YES ☐ NO ☐	**If yes, how many standard drinks per day? 1- 5 ☐ 5-10 ☐ 10+ ☐ Other:**_____	
	How many days per week do you drink? 1- 2 ☐ 3-5 ☐ 5-7 ☐ Other:_____	
Drug Use : YES ☐ NO ☐	**If Yes, Type/s:**	**Frequency:**
Height (cm)	**Waist (cm)**	**Weight (kg)**

Do you have an - If yes, please provide a copy. **Advanced Health Directive? YES ☐ NO ☐** **Enduring Power of Attorney or Guardianship? YES ☐ NO ☐**	**For children under 16 years of age, is there any Court or Parenting Orders in place?** **YES ☐ NO ☐** If yes, please provide a copy.

Do you identify as someone from a culturally and/or linguistically diverse background/heritage? YES ☐ NO ☐

If YES – What is your background/heritage? (*E.g. Asia/India/Pakistan/etc.*)_____

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

Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Do not wish to answer ☐

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.

Please advise reception if you wish to opt out of recalls and health reminders and/or SMS services.

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

☐ **High blood pressure**	☐ **Hepatitis**	☐ **Heart Valve Surgery**
☐ **Angina**	☐**Skin cancer surgery**	☐ **other health Issues – please**
☐ **Diabetes**	☐ **Varicose Veins**	**provide details:**
☐ **Bleeding tendency**	☐ **Deep vein thrombosis**	_____
☐**Stomach Ulcer**	☐ **currently pregnant**	_____
☐ **Asthma**	☐ **HIV**	_____

Next of Kin			**Emergency Contact**		
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 to you the patient / guardian or to other health professionals via telephone, secure electronic communications or post 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 and quality improvement 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 Appointment details, Medication details and Results of Pathology and/or Radiology on your behalf, PLEASE COMPLETE RELEASE OF INFORMATION TO A THIRD PARTY CONSENT FORM at reception.***

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 as 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 Medicare benefits to the provider who rendered the services.

Patient (please print): _____

Signature: _____ **Date:** _____

If not the Patient signing – Your name (please print): _____ **Relationship:** _____

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

_____