Patient Registration Form

Mr ☐ **Mrs** ☐ **Ms** ☐

Surname………………………………………………………………………..

First Name……………………………………………………

Middle Name……………………………………………………………….

Preferred Name……………………………………………………………..

Date of birth ___ ___/ ___ ___/ ___ ___ ___ ___

Male ☐ **Female** ☐ **Other** ☐ ________________

Do you require interpreter? Yes ☐ No ☐

Medicare number: ______________________

Ref number ___________________________

Medicare expiry date: __________ / _________

Vet Affairs number: ____________________

Gold Card ☐ White Card ☐

Vet expiry date __________ / ___________

Do you have a pension/ concession card?

Yes ☐ No ☐

Card number: _________________________

Card expiry ___________________________

Cultural Background

Aboriginal ☐ Torres Strait Islander ☐

Other ethnicity/Cultural Background ☐

____

Mobile: ______________________________

Home: _______________________________

Email: ______________________________

Work: ______________________________

Home Address: _________________________

____

____

Emergency Contact**:** __________________

Relationship _________________________

Contact No: _________________________

Please read and sign the form overleaf

IF YOU HAVE ANY CONCERNS ABOUT ANY SECTION OF THE CONSENT FORM PLEASE DISCUSS WITH YOUR DOCTOR IN YOUR FIRST CONSULTATION.

MEDICAL HISTORY

ALLERGIES /ADVERSE REACTIONS (e.g. medications, dressings, foods) □ No □ Yes – please list____

MEDICATIONS (including any over the counter medications or vitamins) ________________________________

____

Do you have or have ever had

□ Operations ____

□ Any chronic illness____

□ Mental Health problems ____

□ Any other significant past illness____

FAMILY HISTORY □ Cancer □ Asthma □Diabetes □ Heart disease □ Mental illness □ Other

SOCIAL HISTORY

Who do you live with? ____

To assist with appropriate health screening and advice: Do you have sex with □ men □ women? □

Occupation ______________________________________

□ Alcohol ____days per week and _____drinks per day O R □ non-drinker

□ Cigarettes ________day OR quit smoking date ____________ □ Other drug use

Date of last Pap Smear/Cervical Screening test ______________________

Patient consent for use of personal health information

1. I, _________________________ ________________ give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.

2. I give consent that all clinical staff of the practice can access the information on my My Health Record through the practice medical software. My doctor can upload a Shared Health Summary to the My Health Record in consultation with me. I understand that I can inform my doctor at any time if there is sensitive information, I do not want uploaded to My Health Record. I understand that I am responsible for setting the privacy controls on my MHR.

3. I agree to allow my doctor to communicate relevant medical details to specialist doctors, hospital medical staff, pathology labs, and other health care providers, e.g. physiotherapist, podiatrists, psychologists, etc., involved in my medical care. I understand that I can inform my doctor if there is sensitive information I do not want communicated outside of the practice.

4. I understand that this practice may from time to time participate in medical research projects with outside organisations. We stress that all information shared is depersonalised (i.e. Names and identifying details of patients are NOT given).

Your signature Patient/Parent/Guardian____Date_________