New Patient Registration Form

We are committed to providing you with access to quality healthcare providers. Please assist us by completing your new patient details below for your Doctor and for our Staff:

Contact Information	
Gender:	
Title:	
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	

Emergency Contact Details	
Name:	**Relationship to you:**
Home Phone:	
Mobile Phone:	

Next of Kin (if different to the above)	
Name:	**Relationship to you:**
Home Phone:	
Mobile Phone:	

Healthcare Identifiers		
Medicare Number: _____	**Ref: _____**	**Expiry: ___/_____**
Dept. of Veterans' Affairs File Number: _____		**☐ Gold ☐ White**
Concession (Pension/Health Care) Card Number: _____		**Expiry: ___/_____**

Cultural Identity

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities - do you identify as someone from a culturally and/or linguistic diverse background?

☐ No

☐ Yes - Please elaborate_____

If yes, do you require an interpreter service? **☐ No ☐ Yes**

Patient Consent

Please read this consent form carefully prior to signing.

This general practice collects information from you so that your Doctor can provide you with quality healthcare. We require you to provide the Doctor with your full medical history so that the Doctor may properly assess, diagnose and treat illnesses and medical conditions, ensuring they are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 information is used or disclosed.

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the Doctor or practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors, other doctors in this practice 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.
- For legal related disclosure as required by a court of law.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.

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. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ (patient name) have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal 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.

Patient name: (please print) _____

Signature: _____Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian)_____

Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No
☐ Yes – provide details:

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details:
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Other – provide details:

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ No
☐ Ceased - date_____
☐ Yes - how many ___ / day or ___ / week

Alcohol

☐ No
☐ Yes - how many ___ / day or ___ / week or ___ / month

Recreational Drug Use

☐ No
☐ Yes - type_____ frequency _____

Family Health History Information

Have any members of your family have:

☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Mental Illness
☐ Cancer – type:
☐ Other significant - provide details: