PATIENT REGISTRATION FORM

Mr ☐ Miss ☐ Ms ☐ Mrs ☐ Master ☐ **Gender:** Male ☐ Female ☐

Marital status: Single ☐ Married ☐ De-facto ☐ Divorced ☐ Widow ☐ Separated ☐

Family Name (as per Medicare)	
First Name (as per Medicare)	
Date of birth	
Address	
Suburb / Postcode	
Contact number (home)	
Contact Number (work)	
Contact Number (Mobile)	
Email	
Occupation	

Medicare Number		NUMBER NEXT TO YOUR NAME	Exp /
DVA File Number			Exp /
Pension/Healthcare) card number			Exp /

Name of next of kin:	Relationship to you:	Contact Number:
Name OF Emergency:	Relationship to you:	Contact Number:

CULTURAL BACKGROUND *(Knowing your cultural background can help us provide healthcare that meets your individual needs.)*

Are you of Aboriginal or Torres Strait Islander Origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐

Country of Birth: ___________________________________ is English your first Language? YES ☐ NO ☐

Do you, or have you had, any of the following:	**Yes**	**No**	**Details where relevant**
Any allergies			
Heart disease			
High blood pressure			
Stroke or brain haemorrhage			
Asthma			
High cholesterol			
Diabetes or raised blood sugar levels			
Stomach or bowel problems			
Any cancer or tumour, including skin cancers			

OTHER____

SMOKING STATUS

☐ Non-smoker

☐ Ex smoke Quit date ……..………..……….

☐ Smoker Smokes per day ………..……

Year started ……..………..……..………..………..……

Want to quit? ☐ Yes ☐ No ☐ Thinking about it

ALCOHOL INTAKE

☐ Non drinker

☐ Drinker

Frequency

☐ Daily ☐ Weekly ☐ Monthly

How many standard Drinks? …………….

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunizations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

☐ Yes ☐ No

Transfer of Health

You may have records at another practice. If you wish to have a copy or summary of your health records transferred to this practice, please ask reception.

Consent

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat, and be proactive in your health care needs.
We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information.
We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g.,notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

Patient Declaration

- I have read the information above and understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

Patient’s name: ……………………………………………………………………………… **Date:** ………………

Patient’s signature: …………………………………………………………………………..

Signed as Guardian for child: …………………………………………………………….

Name: (printed) …………………………………………………………………………...