**Patient Registration Form**

We are committed to providing the best possible care to our patients. To do this, it is essential that your personal information is accurate and up to date. Please sign the consent form overleaf, to allow us to collect and use your health information.  We ask that you take a moment to complete these forms and direct any questions to reception.

|  |  |  |  |
| --- | --- | --- | --- |
| Title:  |  Mr Dr Mrs Ms Miss       | Marital Status: |  |
| Surname: |  | Gender: |  Male Female Other .   |
| First Name: |  | Date of Birth: |  |
| Middle Name: |  | Preferred Name: |  |
| Street Address: |  | State & Post Code: |  |
| Postal Address:(If applicable) |  | State & Post Code: |  |
| Home Phone: |  | Mobile Phone: |  |
| Work Phone: |  | Fax Number: |  |
| Email address: |  | Occupation: |  |
|  |  |  |  |
| Medicare Number: |  Ref#:( ) | Expiry Date: |  |
| HCC / PCC / CSHC: |  | Expiry Date: |  |
| Veterans Affairs #: |  | Colour / Condition: |  |
| Private Health Fund: |   | Number: |  |
| Extras Cover |  No Yes   | Hospital Cover: |  No Yes   |
| Covered For Ambulance: |  No Yes    | SA Ambulance Cover #: |  |

**HEAD OF FAMILY DETAILS:** Required to process your Medicare claim, complete this section if the patient is a minor.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Are you a patient?  |  No Yes   |
| Address:  |  | Date of Birth: |  |
| Mobile Phone:  |  | Relationship: |  |
| Medicare Number: |  Ref #:( ) | Expiry Date: |  |

**Emergency Contact**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Relationship To You: |  |
| Home Phone: |  | Mobile Phone: |  |
| **Next Of Kin** |
| Name: |  | Relationship To You: |  |
| Home Phone: |  | Mobile Phone: |  |

**Knowing your cultural background can help us to provide healthcare treatments for your individual needs.**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you identify as being of Aboriginal or Torres Strait Islander descent? |  No Yes - Aboriginal   Yes - Torres Strait Islander   Yes – Aboriginal & Torres Strait Islander   | Do you identify as having a culturally / linguistically, diverse background?  |  No   Yes – provide details:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is English your first language? specify |  No Yes   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Do you require an interpreter? |  No Yes    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have an advanced health directive in place, for end of life care? |  No Yes   |

**Payer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Payer: |  | Claim Number: |  |
| Case Manager: |  | Date of Injury: |  |

**Patient Health Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Completed** |  | **Date of Birth** |  |
| **Surname** |  | **First Name** |  |
| Allergies to any medications | **Reaction/s** |  |
| Name |  | Reaction |  |
| Name |  | Reaction |  |
| Name |  | Reaction |  |
| **Current prescription medication/s** |
| Name |  | Strength & Dose |  |
| Name |  | Strength & Dose |  |
| Name |  | Strength & Dose |  |
| Name |  | Strength & Dose |  |
| **Current non-prescription medication/s & supplements** |
| Name |  | Strength & Dose |  |
| Name |  | Strength & Dose |  |
| Name |  | Strength & Dose |  |
| **Lifestyle risks** |  |  |
| Smoking status |  No Yes \_\_\_\_\_\_\_ # p/day   | Quit attempts |  |
| Alcohol Intake |  | Drug use | No Yes \_\_\_\_\_\_\_\_\_\_\_\_   |
| Physical activity |  | Amount per wk |  |
| **Family History** |  | **Marital Status** |  |
| Name of Partner |  | Age |  |
| Childs name |  | Age |  |
| Childs name |  | Age |  |
| Childs name |  | Age |  |
| **Past Family History** | **Conditions** |
| Mother |  | Condition |  |
| Father |  | Condition |  |
| Siblings |  | Condition |  |
| Siblings |  | Condition |  |
| Siblings |  | Condition |  |
| **Medical History** |
| Have you ever had: Diabetes Kidney Disease Asthma Hypertension Stroke      Depression Epilepsy Heart Problems Cancer Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      |
| Condition/ Date |  | Treatments |  |
| **Do you consent to staff obtaining copies of the following results for your appointment? Yes No**   |
| **Surgical History** | **Blood Group** |  |
| Surgery |  | Date |  |
| Last Pap Smear? | Date | Result / next due? |  |
| **Current Observations (for staff use only – to be entered in clinical record)** |

**Health Information Collection and Use Privacy Consent Form**

**Please read this consent form carefully, and sign where indicated below.**

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 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 your personal information, and for its use in the following ways:

* Administrative purposes.
* Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
* Disclosure to others involved in your healthcare. This includes your treating doctor 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 for the purpose of patient care and teaching.
* For research and quality assurance activities to improve individual and community health care and practice management. Only information that does not identify you is used in these circumstances.
* To comply with any legislative or regulatory requirements, such as notifiable diseases.
* For reminders and recalls which may be sent to you regarding your health care and management.

**You can decline to have your health information used in all or some of the ways outlined above, but it may influence our ability to manage your health care to provide the best outcome for you. Please read the statements below carefully and tick each box for which you agree.**

|  |  |
| --- | --- |
| 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 somay 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 circumstanceswhere 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, myfurther 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. |   |
| I understand that if I request access to information, an administration fee may be charged. |   |
| I consent to appointment reminders being sent to me via email, or SMS to my mobile phone. |   |
| I consent to receiving reminders for relevant procedures and reviews via telephone, mail, email, SMS. |   |
| I consent to receiving results via email and am aware that this is not done through a secure network. |   |
| From time to time we update you about opening times, holidays and other practice information. Are you happy to receive this information via email?  |   |
| I am aware that this practice may charge a cancellation fee for non-attendance at an appointment. |   |
| I am aware that this practice provides **some** online services through Health Engine Online, who maintain a secure network for the transmission of medical information & requests. Fees apply for online services.  |   |
| I am aware that my practitioner may decline such a request and if so a full refund will be given. |   |
| I have read and agree to all the information provided regarding practice fees, privacy and freedom of information.  |   |
| I am aware that this practice does NOT bulk bill and that accounts are to be paid in full on the day of consultation. On most occasions an instant rebate from Medicare / Private Health can be provided. |   |
| **OR**I am unsure and would like to discuss this further with someone from the medical practice, prior to signing. |   |
| **Patient Name:** | **Guardian Name:** |
| **Patient / Guardian Signature:** | **Date:** |