

New Patient Registration Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Contact Information	
Title:	Pronouns:
Identifies as: (Please circle) Male Female Non- Binary Transgender Prefer not to answer	Gender Diverse Different Identity
First Name:	Surname:
Preferred Name:	Date of Birth:
Street Address:	
Postal Address: <i>(if different to above)</i>	
Home Phone:	Mobile Phone:
Email:	
SMS/Email consent: (By ticking YES, you consent to receiving SMS texts and/or emails relating to appointment reminders, clinical reminders (recall and result appointments), clinical communication, and health awareness). If you wish to opt out of any of these options, please advise reception. Please Tick: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If registering a child under the age of 16yr: <i>Parent/Guardian</i>	
Name:	Relationship to child:
Date of Birth:	Contact Details:
Next of Kin/ Emergency Contact	
Name:	Relationship to you:
Home Phone:	Mobile Phone:
Emergency Contact – <i>if different from above.</i>	
Name:	Relationship to you:
Home Phone:	Mobile Phone:
Healthcare Identifiers	
Medicare Number:	Ref: Expiry: /
Dept. of Veterans' Affairs File Number:	Gold <input type="checkbox"/> White <input type="checkbox"/>
Pension / Health Care card – <i>please circle relevant card type</i>	
Card Number: _____	Expiry: ____/____/____
Cultural Identity	
To assist with health initiatives – Please tick appropriate option.	
<input type="checkbox"/> Australian, non-indigenous <input type="checkbox"/> Torres Strait Islander but non-Aboriginal <input type="checkbox"/> Aboriginal but not Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Other _____	
Languages other than English: _____ Cultural Background (optional) _____	
If English is not your preferred spoken language, do you require an interpreter service? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Your Health Information	
ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?	
<input type="checkbox"/> No <input type="checkbox"/> Yes – provide specific details: _____	
CURRENT MEDICATIONS – Please list all your current medications: _____	
MEDICAL HISTORY - Do you have or have you had a history of the following?	
<input type="checkbox"/> Surgery – provide brief details: _____	
<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Illness <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Other – provide details: _____	
Eye Health: When did you last have your vision/eyes checked at an optometrist? Month: _____ Year: _____	

Do you have any existing eye/vision issues you are concerned about?

LIFESTYLE RISK FACTOR INFORMATION

Recreational Drug Use

- No
 Yes - type _____ frequency _____

Smoking

- No Ceased – date approx.: _____
 Yes - how many _____ day / _____ week

Family Health History Information

Have any **members of your family** had or currently have

- Heart Disease
 Asthma
 Diabetes
 Hypertension (high blood pressure)

- Mental Illness
 Cancer – type:
 Other significant - provide details:

Patient Consent

Please read this consent form carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, and treat illnesses and medical conditions, ensuring we 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.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment which may be issued by SMS to a mobile number you provide to us.
- Disclosure to others involved in your health care, including treating doctors 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.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

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 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 provided. 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. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

Patient name: (please print) _____

Signature: _____ Date: _____

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

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