PATIENT REGISTRATION AND CONSENT FORM

Surname:	☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Mast**
Given Name:	**Middle Name:**
Preferred Name:	**Date of Birth:** **Sex:**

TO ASSIST WITH HEALTH INITIATIVES - ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?

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

DO YOU IDENTIFY AS PART OF A DIVERSE CULTURE OR BACKGROUND?

☐ No ☐ Yes – Please provide details of Ethnicity _____

Address:		
Suburb and Post Code:		
Home Phone:	**Mobile Phone:**	
Email Address :		
Medicare Number:	☐☐☐☐ ☐☐☐☐☐ ☐ ☐ **Patient Number on Card**	**Expiry:**
DVA Gold/ White **Lilac/Orange** (Please circle)	☐☐☐☐☐☐☐☐	**Expiry:**
Pension Number:	☐☐☐☐☐☐☐☐☐☐☐	**Expiry:**
Health Care Card:	☐☐☐☐☐☐☐☐☐☐☐	**Expiry:**
Occupation:		
Next of Kin: (Name and Number)	Relationship: (father/mother/spouse/etc)	
Emergency Contact: (Name and Number)		

PATIENT CONSENT

To enable ongoing care and total quality improvement within this practice, and in keeping with the Australian Privacy Principles (2014), we wish to provide you with sufficient information on how your personal health information may be used or disclosed. By signing below, you (as a patient/guardian) are consenting that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventative health care including email and SMS.
- For accounting procedures and the collection of professional fees
- The diagnosis and treatment of my condition, including the communication of relevant information only, to practice staff, specialists and other health care providers to ensure quality care is provided.
- For legal related disclosures required by the court of law
- For disease notification as required by law
- For use when seeking treatment by other doctors in this practice
- For obtaining medical records, previous clinical reports and management regimes, etc. from other medical practitioners, institutions, laboratories
- To inform the next of kin identified in my patient information of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent

Signature: _____**Date**:_____

Patient / Guardian Name: _____

HEALTH INFORMATION FORM

Surname:	☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Mast**
Given Name:	**Date of Birth:**

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR ARE YOU SENSITIVE TO DRUGS / DRESSINGS?

☐ Yes (If yes, list below the name, what occurs and how severe the reaction) ☐ No

_____

_____

_____

CHILDREN'S IMMUNISATIONS - IF COMPLETING THIS FORM FOR A CHILD ARE THEIR IMMUNISATIONS UP TO DATE?

☐ Yes ☐ No

_____

YOUR CURRENT HEALTH - DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

☐ Asthma ☐ Diabetes ☐ Mental Health Concerns ☐ Cancer ☐ Heart Disease

☐ Operations ☐ Gastro-Intestinal ☐ Reflux

Current medications including vitamins and supplements: (Inc. dosage)

_____

_____

_____

IT IS IMPORTANT FOR YOUR DOCTOR KNOW ABOUT ANY OF THE FOLLOWING

FAMILY & SOCIAL HISTORY ☐ No Significant Family History

Mother Alive? ☐ YES ☐ NO Cause of Death: _____

Father Alive? ☐ YES ☐ NO Cause of Death: _____

SIGNIFICANT FAMILY HISTORY

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Colon Cancer ☐ Breast Cancer ☐ Depression

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Colon Cancer ☐ Depression

SOCIAL HISTORY

Do you live alone? ☐ Yes ☐ No What activities do you like to do? _____

Are you the sole carer for another person? ☐ Yes ☐ No _____

Marital Status: _____ Do you have a disability? ☐ Yes: _____

HEALTH INFORMATION FORM

Surname:	☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Mast**
Given Name:	**Date of Birth:**

CURRENT ALCOHOL INTAKE ☐ Non-Drinker

Days per week ☐ Standard Drinks per day ☐

How often do you have 6 or more drinks in any one occasion?

NEVER ☐ MONTHLY ☐ WEEKLY ☐ DAILY ☐

CURRENT SMOKING HISTORY

☐ Non-Smoker ☐ Ex-Smoker ☐ Smoker

Year Started ☐ Year stopped ☐ How many cigarettes in a day? ☐

FOR THOSE 65 YEARS AND OLDER: WHEN WAS THE LAST TIME YOU WERE IMMUNISED?

Influenza	Date: _____	☐ not sure	☐ never
Pneumococcal Pneumonia	Date: _____	☐ not sure	☐ never
Tetanus	Date: _____	☐ not sure	☐ never
Gardasil	Date: _____	☐ not sure	☐ never

Females: When did you last have?

Pap smear	Date: _____	☐ not sure	☐ never
Breast Check	Date: _____	☐ not sure	☐ never

Males: When did you last have an overall check-up? Date: _____ ☐ not sure ☐ never

HEIGHT: ☐ **WEIGHT:** ☐

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