North Geelong Medical Clinic

Patient Registration Form

Title: Mr / Mrs / Miss / Ms / Mast / Other_____

First Name: _____ **Middle Name:** _____ **Surname**: _____

Preferred Name: _____ **DOB:** _____ **Birth Sex:** Female Male Other

Gender Identity: _____ **Pronouns:** _____

Country of Birth/ Ethnicity :_____

To assist with health initiatives, are you Aboriginal or Torres Strait Islander?

□ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander □ No □ Prefer not to say

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Address

Street Address: _____

Suburb: _____ Postcode: _____

Postal Address (if different from above)

P O Box/Street: _____

Suburb: _____ Postcode: _____

Mobile No. _____ **Home Ph. No**. _____ **Work Ph. No**. _____

Email Address: _____

1.Next of Kin:

Name: _____

Phone No: _____

Relationship: _____

2 Emergency Contact (must be different to Next of Kin)

Name: _____

Phone No: _____

Relationship: _____

Medicare No: _____ **Position on card:** _____ Expiry Date: _____

Concession No: _____ **Concession type:** _____ Expiry Date: _____

DVA No: _____ **DVA type:** _____ Expiry Date: _____

Private Health Fund: _____ **Membership No:** _____

SMS/Email Consent

Do you authorise the practice to send you SMS/email appointment confirmations via AutoMed/Best Practice?

□ Yes □ No

Do you authorise the practice to send you SMS messages regarding results or recalls via AutoMed/Best Practice?

□ Yes □ No

North Geelong Medical Clinic

Our practice provides our patients with preventative care and early case detection reminders (e.g., immunisations, annual health checks, skin checks, cervical screening). Do you wish to have any relevant reminders sent to you?

□ Yes – via SMS or □ Yes – via mail □ No

Signature: _____

Please return completed form to reception with your Medicare card and current concession card if applicable.

North Geelong Medical Clinic is a private billing practice, payment is expected and appreciated on the day of consult.

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance 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/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 preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- 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.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken, and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____

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Medical Information

Do you have any allergies or are you sensitive to any medications?

□ Yes □ No

If yes, please list:

_____

_____

_____

Do you have or had a history of the following? (please include details and date of diagnosis if known)

Operations: □ Yes □ No _____

Asthma: □ Yes □ No _____

Diabetes: □ Yes □ No _____

Hypertension: □ Yes □ No _____

Chronic Illness: □ Yes □ No _____

Other: □ Yes □ No _____

_____

Do you smoke? □ Yes □ Never smoked □ Ex-smoker

If currently smoking: How many per day: _____ If Ex-smoker: Year Quit: _____

Do you drink Alcohol? □ Yes □ No

If Yes: how many per day: _____ How many days per week: _____

Preventative Health Screening

Have you had a bowel screening test? □ Yes □ No

If yes, date last performed: _____

Have you had a mammogram? □ Yes □ No

If yes, date last performed: _____

Have you had a cervical screening test (e.g., pap smear?) □ Yes □ No

If yes, date last performed: _____

How did you hear about our practice?

_____

Office use – scan into patient file -BP comms Consent – Link to signed consent