Patient Registration

Mr / Miss / Ms / Mrs **(Please circle)** Family Name: _____

Given Names: _____

Date of birth: __ __ / __ __ / __ __ __ __

Gender: Male ☐ Female ☐ Other ☐ _____

Do you identify as: Australian: non-Indigenous ☐ Aboriginal but not Torres Strait Islander ☐
Torres Strait Islander but not Aboriginal ☐ Both Aboriginal and Torres Strait Islander ☐

Other:_____

Address: _____

Suburb: _____ State: _____ Post Code: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Would you like SMS reminders? Yes ☐ No ☐

Email: _____

I consent to receive email communication regarding my medical care ☐

Medicare: __ __ __ __ __ __ __ __ __ __ __ Ref no.: __ Expiry Date: __ __ / __ __ __ __

Commonwealth Pension: __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ / __ __ __ __

Commonwealth Seniors Health: __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ / __ __ __ __

Commonwealth Health Care: __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ / __ __ / __ __ __ __

DVA: _____ Gold ☐ White ☐

Next of Kin

Name: _____

Address: _____

Suburb: _____ Post Code: _____

Phone: _____

Relationship: _____

Emergency Contact / Same as Next of Kin ☐

Name: _____

Address: _____

Suburb: _____ Post Code: _____

Phone: _____

Relationship: _____

Occupation: _____

Marital Status: _____

How Did You Hear About Us? _____

I agree to pay all accounts on the day of consultation.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Staff Initials _____ / Reg Dr ☐ / Medicare Chk ☐ / Consent signed ☐ / P3 sent with pt to Dr ☐

Health Information Collection and Use Consent Form

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 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.

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.

- ✓ I understand 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 that 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.
- ✓ I understand YourGP@Crace, YourGP@Denman and YourGP@Lyneham are NOT bulk-billing practices and agree to pay the fee at the completion of the appointment.

OR

☐ I am unsure and would like to discuss this further with someone from the medical practice before I sign.

Patients Name: _____

Signature: _____

If patient under 16 signed by parent or guardian

To be completed and handed to your doctor

Are you allergic to any medications: Yes ☐ No ☐

If Yes, please list the medication/ingredient and reaction:

Medication	Reaction

Smoking history:

Current smoker: Yes ☐ No ☐

If yes, what year did you start:
If yes, how many per day:
If you were a smoker and have stopped, what year did you stop?

Are you a: Light smoker ☐ Moderate smoker ☐ Heavy smoker ☐

Alcohol History:

Do you drink alcohol (If less than 1 day a week, mark No): Yes ☐ No ☐

If yes, how many per days per week:
How many drinks per day would you average: