Patient Registration Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate information. If you have concerns, please leave blank and discuss with your GP.

PERSONAL DETAILS

Surname: _____ Given Name/s: _____

Date of Birth: _____/_____/_____ Gender: Male / Female / Other

Marital Status (circle): Single, Married, Divorced, De Facto, Widowed, Other

Address: _____ Suburb: _____

Home Phone: _____ Mobile: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Next Of Kin (if different): _____ Relationship: _____ Phone:_____

Medicare number: _____ Expiry _ _/_ _ PRN No. ___

Pension number: _____ Expiry: _ __/_ __

Health Care Card: _____ Expiry: _ __/_ __

Seniors Card: _____Expiry: _ __/_ __

Are you of Aboriginal or Torres Strait Islander origin? Yes / No

Country of Birth_____

Ethnicity_____

Current Occupation: _____

Previous Doctor: _____

Previous Doctor's Address: _____

Usual Pharmacy: _____

Other family members attending this practice:

_____

Preferred language: _____

Any special needs: _____

MITTAGONG MEDICAL CENTRE

YOUR HEALTH HISTORY

Do you have any allergies to medicines or anything else? Yes □ No □

To what? _____

Reaction? _____

Have you ever had:	***Year began***	***Active now✓***		***Year began***	***Active now✓***
Operations			Hay fever/ sinus problems		
Asthma			Skin rashes, dermatitis, eczema, psoriasis		
Diabetes			Epilepsy/fits/blackouts/strokes		
Hypertension			Migraine		
Chronic illness			Gout		
Thyroid problem			Other		

CURRENT MEDICATIONS (including over the counter medication)

Name of medication	***Strength***	***Times taken***

SOCIAL

	No	**Not Anymore**	**Yes, now**	
• Cigarette	□	□	□	_____ per day
• Alcohol	□	□	□	_____ per week
• Intravenous drugs	□	□	□	_____
• Other drugs (eg marijuana)	□	□	□	_____
• Exercise	□	□	□	_____

PREVENTATIVE HEALTH

When was your last check for the following	***Year***		***Year***
Cholesterol		Bowel cancer	
Blood Pressure		HIV test	
Prostate check		Hepatitis test	
Pap smear			

IMMUNISATIONS:

Have you had the following immunisations?	Year
Tetanus Booster	
Hepatitis B	
Hepatitis A	
Pneumococcal	
Polio	
Rubella	
Influenza	

CHILDREN'S IMMUNISATIONS:

If completing this form for a child, are their immunisations up to date?

Yes □ No □

FAMILY HISTORY:

Has anyone related to you ever had	**Relationship to you**	**Ever had ✓**	**Age of onset**	**Died from ✓**	**Age at death**
High blood pressure					
High cholesterol					
Heart attack/angina					
Stroke					
Anaemia					
Bleeding disorder					
Asthma /emphysema					
Tuberculosis					
Arthritis					
Diabetes					
Kidney disease					
Cancer or tumor					
Other					

REMINDER SYSTEM

Our practice uses the HotDoc recall system to improve the quality of your health care. Reminders are sent via push notification or sms for health assessments, vaccines, skin checks, screening.

I consent to receiving reminders for quality improvement activities at this practice: Yes □ No □

TRANSFER OF HEALTH INFORMATION

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health record transferred to this practice. Please ask the receptionist for information about how this can take place.

CANCELLATION POLICY

As a courtesy to the doctors and other patient's, if you are unable to attend your appointment please cancel with as much notice as possible. Patients who fail to attend, or who give less than 3 hours' notice to cancel their appointment will incur a cancellation fee.

Health Information Collection and Use Consent Form

As a patient of our practice we ask you to provide us with your personal details & 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. Please ask for a copy of our privacy policy, which details the collection, use & disclosure of your health information.

We require your consent to collect your personal information and to use the information provided in the following ways. Please read this consent form carefully, and sign where indicated below.

- 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.
- Doctors at Mittagong Medical Centre may exchange medical information with other doctors or medical service providers when considered necessary for medical welfare. I understand I have the right to request my nominated treating doctor NOT release certain information.

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 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 the quality of health care/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 above purpose, subject to any limitations on access/disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with my doctor before I sign.	☐

Patients Name: _____ Date: _____/_____/_____

Patient's signature: _____

Signed as Guardian for Child: _____ Name (printed): _____