New Patient Registration Form

Patient Details

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname: _____ First Name: _____

Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female ☐ Other: _____

Street Address: _____

Suburb: _____ Postcode: _____

Phone: H _____ W _____ M _____

Email: _____

Healthcare Identifiers

Medicare Card Number _____ Ref: ____ Expiry: _____

Pension Card Number _____ Expiry: _____

Healthcare Card Number _____ Expiry: _____

DVA Card Number _____(Gold/White/Orange) Expiry: _____

Next of Kin

Name: _____ Relationship: _____ Phone: _____

Emergency Contact (if different to Next of Kin)

Name: _____ Relationship: _____ Phone: _____

Past Medical Records/History

Would you like to transfer your past medical records/history to MGMC?

☐ No ☐ Yes: Please approach Reception Staff to get a Transfer Form

My Health Record

Would you like to register for My Health Record? ☐ Yes ☐ No

Cultural Identity

Are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

What is your country of birth: _____

Do you require an interpreter service? ☐ No ☐ Yes

Your Medical History

Do you or have you had a history of the following? (please elaborate)

☐ Operations _____ ☐ Asthma _____

☐ Diabetes _____ ☐ Hypertension _____

☐ Chronic Illness _____ ☐ Mental Health Diagnosis _____

☐ Other: _____

Current Medications

Please list all current medications including complementary and over the counter medications, vitamins and minerals:

_____ _____

_____ _____

Allergy Information

Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes, please specify: _____

Children's Immunisations

If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders (e.g. immunizations, annual health checks, skin checks and pap smears)

Do you agree to having relevant health reminders sent to you: ☐ Yes ☐ No
If yes, do you agree to having these reminders sent to you via Email or SMS ☐ Yes ☐ No

How did you hear about us?

☐ Google / Website ☐ Family/Friend's Referral ☐ Driven Past
☐ Live locally ☐ Letter Box Drop ☐ Other _____

Medical Record Charge

If you would like to transfer Your Medical Records (other than the health summary) to other practice, a $30 handling fee will apply.

Patient Family and Social History

☐ Unknown (e.g. Adopted) ☐ No Significant Family History

Mother alive? ☐ Yes ☐ No Age of death: _____ Cause of death: _____

Father alive? ☐ Yes ☐ No Age of death: _____ Cause of death: _____

Significant Family History

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

Social History:

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Sexuality: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Elite Sport: ☐ Yes ☐ No

Advance Care Directive: ☐ Yes ☐ No

Enduring Power of Attorney: ☐ Yes ☐ No

Recreation Activities: _____

Accommodation: ☐ Own home ☐ Nursing Home ☐ Others _____

Live with: ☐ Spouse ☐ Relative ☐ Friend ☐ Alone

Is a Carer: ☐ Yes ☐ No

Has a Carer: ☐ Yes ☐ No

Do you feel safe in your own home: ☐ Yes ☐ No

ADF Service: ☐ Never served ☐ Current ADF – Permanent member ☐ Current ADF – Reserve ☐ Past ADF – Permanent or Reserves

Current Alcohol Intake: ☐ Non Drinker

Days per week: _____ Standard drinks per day: _____

Current Smoking History

☐ Non-smoker ☐ Ex-smoker ☐ Smoker

☐ Cigarettes
☐ Cigars Cigarettes per day: _____ Year started: _____
☐ Pipe

Past Smoking History

Quantity/day ☐ Unknown ☐ <1 ☐ 1-9 ☐10-19 ☐ 20-39 ☐ 40+

Year started: _____ Year stopped: _____

Patient Consent

Please read this consent form carefully prior to signing.
This practice values privacy and security of your personal information. We require you to provide us with your personal details and full medical history so 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*, our aim is 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.

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 and preventative healthcare, frequently issued by SMS.
- 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 legal related disclosure as required by a court of law.
- 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 contained within in the patient consent and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. 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.

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. 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.

Patient name: (please print) _____

Signature: _____ Date: _____

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

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