Patient Registration & Consent Form

Provincial Medical Centre

Accredited General Practice

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.
ALL patients are asked to complete the following.

Family Name:..... **Given Name:**.....

Preferred Name:..... **Date of Birth:**.....

Occupation:..... **Title: Mr Mrs Miss Ms Dr Other**.....

Address:.....

Suburb:..... Postcode:.....

Mobile No:..... Home No:.....

Work No:..... Email:.....

Next of Kin: *Best person for us to contact on your behalf in case of an emergency.*

Name:..... **Relationship:**.....**Phone:**.....

Emergency Contact: ***Must** be different to Next of Kin.*

Name:.....**Relationship:**.....**Phone:**.....

Do you identify yourself as: ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither**

Ethnicity:.....**Country of Birth:**.....**Year arrived in Australia:**.....

☐ **Private Health Fund** **Name:**..... **Level:**.....

Medicare Number:.....	Exp:...../.....Ref:.....
Pension/Health Care Card:.....	Exp:...../.....
Dept. of Veteran's Affairs:.....	Exp:...../.....

Current Medications (including over the counter medications, vitamins and minerals):

.....

Do you have any **allergies** and / or are you **sensitive to any drugs or dressing?** ☐ **Yes (please list)** ☐ **No**

.....

SOCIAL & LIFESTYLE HISTORY:

Alcohol: ☐ Non-drinker Drinker ☐

How often do you have a drink containing alcohol: ☐ Never ☐ Monthly or less ☐ 2-4 times per month

☐ 2-4 times per week ☐ 4 + times per week

How many standard drinks containing alcohol would you have on a typical day:

☐ 1-2 Drinks ☐ 3-4 Drinks ☐ 5-6 Drinks ☐ 7-9 Drinks ☐ 10 + Drinks

How often would you consume 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

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Tobacco: ☐ I have never smoked ☐ Ceased Smoking **/ YEAR**…… Smoker …… per day/week

How many days per week do you usually do 30 minutes of <u>BRISK</u> walking or moderate physical activity that increases your heart rate or makes you breath harder?

☐ 1 Day ☐ 2 Days ☐ 3 Days ☐ 4 Days ☐ 5 Days ☐ 6 Days ☐ 7 Days ☐ Never

How many days per week do you usually do 20 minutes of <u>VIGOROUS</u> physical activity? Eg: Running, Swimming, Aerobics, tennis, bike riding

☐ 1 Day ☐ 2 Days ☐ 3 Days ☐ 4 Days ☐ 5 Days ☐ 6 Days ☐ 7 Days ☐ Never

YOUR HEALTH HISTORY:

Height:……..cms Weight:……..kgs Waist measurement:……..cms

If 50 years or older, have you had a test as part of the National Bowel Cancer Screening Program?

☐ Yes ☐ No

Do you suffer from, or are you affected by, any of the following?

Diabetes: ☐ Yes ☐ No Chronic illness: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No Hypertension: ☐ Yes ☐ No

Other: If yes, please provide details……

PAST OPERATIONS **BLOOD GROUP**:……

Date:……Details:……

Date:……Details:……

FEMALES: When did you last have a:

Pap Smear: Date:……☐ Not sure ☐ Never

Breast Check: Date:……☐ Not sure ☐ Never

Mammogram: Date:……☐ Not sure ☐ Never

FAMILY HISTORY: Please list any members of your family who have been diagnosed with, or suffered from:

Diabetes: ☐ Yes ……

Asthma: ☐ Yes ……

Heart Disease: ☐ Yes ……

Cancer (please state type): ☐ Yes ……

Other: ☐ Yes ……

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CHILDREN'S IMMUNISATIONS:

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

IMMUNISATIONS:

An up to date record of your current immunisation status is valuable medical information.

Tetanus	Pneumococcal	Any other relevant immunisations
Flu	Measles	you may have had
Hepatitis A (1 & 2)	Hepatitis B (1, 2 & 3)	
Gardasil (1, 2 & 3)	Polio	

Prior to attending your appointment, if possible, please check if you have this information. If so, it would be greatly appreciated if you could bring it with you or discuss it with our Practice Nurse or Doctor.

Reminder & Recall System:

- The practice routinely makes appointments, recalls & reminders to patients by SMS or Phone.

  If you do NOT wish to have reminders sent, please advise our reception/nursing staff.

- Our practice provides our patients with health information, preventative care and early case detection reminders by SMS, email, mail or by phone eg; immunisations and pap smears.

  If you do NOT wish to received such reminders or health information, please advise our reception/nursing staff.

I agree to my health record or de- identified information being reviewed as a part of quality improvement activities at this practice.

Is there any other information that you believe we should know that may affect or have an influence on the medical treatment / advice you will be provided with?

If **Yes,** please provide details ……..

……..

……..

……..

Thank you for providing us with this information which will allow us to provide you

With a high standard of m

Medical care.

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Please read this consent form carefully, and sign where indicated below.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that 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, we wish 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.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (eg. Specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, any that it may be used or disclosed by the practice for the following purposes.

- Administration purposes in running our general practice.
- Billing purposes, including compliance with Medicare & Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including doctors and specialist outside this medical practice This may occur through referral, or for medical tests included 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, doctors, locums, allied health & staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements eg. Notifiable diseases.
- For use when seeking treatment by other doctors, locums, allied health & staff in the 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 above and understand the reasons why my information is to 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 my permission for my personal information to be collected, used and disclosed as described above (including electronic communication, primarily SMS to my mobile where applicable. May also include email, secure messaging or facsimile. 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's Name: _____ Date: _____ DOB: _____

Patient's Signature: _____

Signed as Guardian/Caregiver/Parent: _____

Your relationship to patient eg. mother, father, daughter, guardian: _____