

New patient registration

We are committed to providing our patients with the best care. Therefore, please assist us by completing the following questions, to ensure your health record is accurate. Where applicable, please circle your selected response. *Thank-you.*

1 Personal details

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

Surname: _____

Given name: _____

Preferred name: _____

Date of birth: _____ / _____ / _____ Gender: *Female / Male*

Address: Street: _____

Suburb: _____ Postcode: _____

Is your postal address the same as above: Yes / No If no, please list below:

Suburb: _____ Postcode: _____

Home: _____ Work: _____

Contact numbers: Mobile: _____

*Do you consent to SMS reminders: Preferred number: Home / Work / Mobile
Yes / No*

eMail address: _____

Occupation: _____ Recreational activities: _____

Do you have a Personally Controlled eHealth (PCEHR) Record? Yes / No

If no, would you like to register? Yes / No

If yes, please see a Reception team member.

Medicare: Card number: _____
 Reference number: _____ Expiry: _____

Health care card or pension card: Reference number: _____ Expiry: _____

DVA card number: Card colour: _____ Expiry: _____

Private health cover: Fund name: _____ Number: _____

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

Do you identify as someone from a culturally and / or linguistic diverse background? No Yes - please elaborate (country): _____
 Interpreter required. If yes, please specify language / dialect: _____

How did you hear about us?

<input type="checkbox"/>	Family / Friend	<input type="checkbox"/>	Westfield Garden City Shopping Centre
<input type="checkbox"/>	Newspaper	<input type="checkbox"/>	Garden City Medical Centre Flyer / Brochure
<input type="checkbox"/>	Facebook	<input type="checkbox"/>	Other

2 Next of kin / emergency contact

Name: _____ Relationship to you: _____

Address: _____
 Suburb: _____ Postcode: _____

Contact numbers: Home / Work: _____ Mobile: _____

Is the person you listed as your next of kin, also your emergency contact: Yes / No

If no, please list your emergency contact below:

Name: _____ Relationship to you: _____

Address: _____
 Suburb: _____ Postcode: _____

Contact numbers: Home / Work: _____ Mobile: _____

3 Medical history

Do you have a history of / suffered from:

<i>Cardiovascular:</i>	<i>High blood pressure</i>	Yes	No	<i>High cholesterol</i>	Yes	No
	<i>Heart attack</i>	Yes	No	<i>Stroke or TIA</i>	Yes	No
	<i>(+/- coronary bypass / stent)</i>					
<i>Respiratory:</i>	<i>Asthma</i>	Yes	No	<i>Chest & lung disease</i>	Yes	No
<i>Other:</i>	<i>Diabetes</i>	Yes	No	<i>Kidney problems</i>	Yes	No
	<i>Cancer (any type)</i>	Yes	No	<i>Epilepsy</i>	Yes	No
	<i>Bowel polyps</i>	Yes	No	<i>Mental illness</i>	Yes	No
	<i>Depression / anxiety</i>	Yes	No			

Do you have any allergies / adverse reactions to medicines / other substances (such as latex/food)?
 Yes / No If yes, please list:

Are you currently taking any medications, including over the counter, vitamins or minerals?
 If yes, please list:

Please list all past and current conditions:

Medical problems

Surgeries

Date of last Pap Smear: (if known): _____

Date of last Mammogram: (if known): _____

Date of last Male Health Check: (if known): _____

Date of last Breast Check: (if known): _____

Social history

Tobacco: Never or _____ per day / week or date ceased smoking _____

Alcohol: Never or _____ per day / week or date ceased drinking _____

Height: _____ Weight: _____

Family History	<i>If living, age</i>	<i>Medical conditions</i>	<i>If deceased, age</i>	<i>Cause of death</i>
<i>Father</i>				
<i>Mother</i>				
<i>Brother</i>				
<i>Sister</i>				
<i>Other</i>				

4 Patient Consent

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice participates in the National & State reminder system (e.g. PAP QLD, PAP register, Australian Childhood Register).

This medical practice collects information from you for the primary purpose of providing health care.

Your doctor in the course of a consultation may ask personal details and a full medical history so that he/she may properly assess, diagnose, treat and be proactive in your health care needs.

This means information may be used in the following way:

- administrative purposes for running the medical centre
- billing purposes including compliance with Medicare and Health Insurance Commission requirements
- disclosure to other doctors in the practice, locums and by registrars attached to the practice for the purpose of care and teaching. Please let us know if you do not want your records assessed for these purposes and we will note your chart accordingly.
- disclosure for practice accreditation which is used to improve individual and community health care and practice management. Please let us know if you do not want your records assessed for these purposes and we will note your chart accordingly.

I have read the information above and understand the reasons why my information must be collected.

I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obligated to provide information requested for me, but failure to do so may compromise the quality of health care and treatment received.

I am aware of my right to access information collected about me, except in some circumstances where access might be legally withheld.

I understand 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 above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purpose set out above subject to any limitations on access or disclosure that I notify the practice of.

Signature: _____ Date: _____

OFFICE USE ONLY

Entered into B.P.: Yes / No Date: _____ Initials: _____ Rechecked / validated: Yes / No Date: _____ Initials: _____