New patient registration

Welcome, and thank-you for selecting Garden City Medical Centre. We are committed to providing our patients with the best care. Therefore, please assist us be 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* *Miss* *Mst.* *Other*

SURNAME

GIVEN NAME *Preferred name*

DATE OF BIRTH / / **GENDER** *Female* *Male* *Other*

CONTACT NUMBERS *Home* *Work*

Mobile *Preferred number:* Home / Work / Mobile

EMAIL ADDRESS

Do you consent to SMS reminders? Yes / No *Do you consent to eNewsletters?* Yes / No

RESIDENTIAL ADDRESS *Postcode*

Is your postal address the same as your residential address? Yes / No

If no, please list below.

POSTAL ADDRESS *Postcode*

OCCUPATION

RECREATIONAL ACTIVITIES

Do you have a My Health Record? Yes / No If no, would you like to register? Yes / No

- If yes, please see a Reception team member.

2 Health identifiers

MEDICARE *Card number* ____ *IRN* ____ *Expiry* ____

CONCESSION ENTITLEMENT Yes / No *If yes, which type?* Pension card Health care card

Card number ____ *Expiry* ____

DVA ENTITLEMENT *Card number* ____ *Conditions:* Gold White Orange

PRIVATE HEALTH Yes / No *Fund name* ____ *Membership number* ____

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

Are you from a culturally and / or linguistic diverse origin? Yes / No

If yes, which country? ____

Interpreter required? Yes / No *Language / dialect* ____

3 How did you hear about GCMC?

- ☐ Family / Friend
- ☐ GCMC Flyer / Brochure
- ☐ Westfield Garden City Shopping Centre
- ☐ GCMC Website
- ☐ Online Search
- ☐ HealthEngine Appointment Portal
- ☐ Facebook (GCMC Page)
- ☐ YouTube (GCMC Channel)
- ☐ LinkedIn (GCMC Page)
- ☐ Twitter (GCMC Account)
- ☐ Allied Health Provider
- ☐ Corporate Partner Referral
- ☐ Newspaper
- ☐ HealthDirect Portal
- ☐ Other

4 Next of kin / emergency contact

NAME ____ *Relationship to you* ____

RESIDENTIAL ADDRESS ____ *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** ____

RESIDENTIAL ADDRESS ____ **Postcode** ____

CONTACT NUMBERS **Home / Work** ____ **Mobile** ____

My Health Record
Accredited General Practice

5 Medical history

Do you have a history of / suffered from, any of the following health conditions?

Cardiovascular		*Respiratory*		*Other*	
• High blood pressure	Yes / No	• Asthma	Yes / No	• Diabetes	Yes / No
• Heart attack (+/- coronary bypass / stent)	Yes / No	• Chest / lung disease	Yes / No	• Kidney disease	Yes / No
• Stroke / Transient ischaemic attack	Yes / No	• Cardiopulmonary disease	Yes / No	• Blood disorder	Yes / No
• High cholesterol	Yes / No	*Neural*		• Arthritis	Yes / No
		• Epilepsy	Yes / No	• Bowel polyps	Yes / No
		• Depression / anxiety	Yes / No	• Bladder control	Yes / No
		• Mental illness	Yes / No	• Cancer (any type)	Yes / No

Overview		*Details*
• Do you have any allergies?	Yes / No	______________________________
• Do you have any adverse reactions to medicines / other substances (such as latex/food)?	Yes / No	______________________________
• Are you currently taking any prescribed medications?	Yes / No	______________________________
• Are you currently taking any other medications (including over the counter; vitamins / minerals: supplements)?	Yes / No	______________________________
• Medical conditions (current or past)	Yes / No	______________________________
• Medical procedures / surgeries (current or past)	Yes / No	______________________________
• Immunisations	Yes / No	______________________________

- Date of last health check *(If known)* __________
- Date of last mammogram *(If known)* __________
- Weight __________
- Current chronic diseases management plan Yes / No
- Date of last pap smear *(If known)* __________
- Height __________

6 Family history

Relative	*If living, age?*	*Medical conditions*	*If yes, details?*	*If deceased, age?*	*Cause of death*
• Mother	__________	*Yes / No*	____________________	__________	____________________
• Father	__________	*Yes / No*	____________________	__________	____________________
• Brother	__________	*Yes / No*	____________________	__________	____________________
• Sister	__________	*Yes / No*	____________________	__________	____________________
• Other	__________	*Yes / No*	____________________	__________	____________________

7 Social history

Tobacco	Non-smoker	or	__________	per day / week	or date ceased smoking	__________
Alcohol	Non-drinker	or	__________	per day / week	or date ceased drinking	__________

8 Patient consent

We require your consent to collect personal information about you.
Please read this information 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 (e.g. specialist correspondence).

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 above 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) ____________________

OFFICE USE ONLY

Entered into B.P.	Yes / No	*Date*		*Initials*		*Treating Doctor*	
Rechecked / validated	Yes / No	*Date*		*Initials*			