VICTORIA STREET CLINIC NEW PATIENT REGISTRATION FORM

WE ARE COMMITTED TO PROVIDING OUR PATIENTS WITH THE BEST CARE, TO DO THIS IT IS ESSENTIAL YOUR MEDICAL RECORDS ARE UP TO DATE & ACCURATE.

TITLE: **SEX: (Please Circle) M F OTHER** **DOB:**

FIRST NAME: **SURNAME:**

ADDRESS:

HOME PH: **MOBILE:**

WORK PH: **OCCUPATION:**

EMAIL ADDRESS:

NEXT OF KIN:

RELATIONSHIP: **PH:**

EMERGENCY CONTACT:

RELATIONSHIP: **PH:**

ARE YOU HAPPY FOR US TO CONTACT THIS PERSON IN CASE OF EMERGENCY? _____

DO YOU WISH TO IDENTIFY AS BEING ABORIGINAL, TORRES STRAIT ISLANDER OR ANY OTHER CULTURAL BACKGROUND?

DO YOU REQUIRE AN INTERPRETER?

REMINDER SYSTEMS – OUR PRACTICE PROVIDES OUR PATIENTS WITH PREVENTATIVE CARE REMINDINERS INCLUDING IMMUNISATIONS, ANNUAL HEALTH CHECKS, PAP SMEARS ETC.

DO YOU CONSENT TO HAVE RELEVANT HEALTH REMINDERS SENT TO YOU?

DO YOU CONSENT TO BE CONTACTED VIA TEXT MESSAGE FOR APPOINTMENT REMINDERS, RECALLS OR OTHER HEALTH SERVICES?

DO YOU HAVE ANY ALLERGIES – Reaction and Severity?

DO YOU HAVE ANY PAST MEDICAL HISTORY/OPERATIONS OF NOTE?

IF COMPLETING FOR A CHILD, ARE THEIR IMMUNISATIONS UP TO DATE? _____

DO YOU HAVE ANY CURRENT HEALTH ISSUES?

ARE YOU ON ANY MEDICATIONS (PLEASE LIST)**?**

DO YOU HAVE ANY FAMILY MEDICAL HISTORY OF NOTE E.G MOTHER OR FATHER WITH HEART CONDITIONS, BLOOD PRESSURE PROBLEMS, DIABETES ETC?

Father -

Mother -

ARE YOU REGISTERED FOR THE NATIONALLY RECOGNISED "MY HEALTH" RECORD?

SOCIAL HISTORY (PLEASE CIRCLE)

SMOKING STATUS: NON SMOKER CURRENT SMOKER Daily Amount _____ EX-SMOKER (Year Stopped) _____

ALCOHOL STATUS: NON DRINKER STANDARD DRINKS _____ /day DAYS PER WEEK _____

DRUG USE (TYPE & FREQUENCY): _____

PHYSICAL ACTIVITY OF NOTE: _____

IS THERE ANYTHING ELSE YOUR GP SHOULD BE AWARE OF?

CONFIRMATION OF IDENTITY SIGHTED - RECEPTIONIST SIGNATURE: _____

LICENCE/PASSPORT OR PHOTO ID CARD NUMBER: _____

OR

MEDICARE CARD: _____

CONCESSION CARD:_____
&
OFFICAL DOC WITH NAME & ADDRESS (eg bank statement) : _____

TRANSFER OF MEDICAL RECORDS; If you request to transfer your medical records to another practice there will be a small fee involved. This fee covers administration costs of photocopying, data discs and registered post.

Patient Consent in line with the Australian Privacy Principles

It is important that you understand how your personal health information may be used in your healthcare. Patients should read the Implied Consent Statement below. If you wish to discuss any aspect of the management of your health records, please speak with your GP.

Your medical record is a confidential document. It is the policy of this Practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff.

Implied Consent

Privacy Amendment (Private Sector) Act

(IMPLIED CONSENT IS AGREEMENT THAT CAN BE INFERRED FROM AN INDIVIDUAL'S CONDUCT)

- Please be advised that the Doctors and staff of Victoria Street Clinic will collect and record such information about persons who present at this practice seeking medical advice, as is necessary for the primary purpose of providing quality health care or for a secondary purpose, which is related to the primary purpose, i.e. referral to a specialist, pathology etc.

- Information collected with your consent can only be used to provide your care or in circumstances related to public interest such as law enforcement and public or individual health and safety. If it is desired that the information be used for other purposes, e.g. research or statistics, your specific consent for each such use must be obtained.

- We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means that we will use the information you provide in the following ways:
- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- 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.
- Disclosure to other Doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. (You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement in research or quality assurance activities).

IT IS IMPORTANT THAT YOU UNDERSTAND THAT WHILST YOU ARE NOT OBLIGED TO PROVIDE ANY INFORMATION REQUESTED OF YOU, YOUR FAILURE TO DO SO MIGHT COMPROMISE THE QUALITY OF THE HEALTH CARE AND TREATMENT THAT CAN BE PROVIDED TO YOU. BY MAKING AN APPOINTMENT TO SEE A DOCTOR AT EITHER PRACTICE YOU WILL BE DEEMED TO HAVE GIVEN CONSENT TO THE COLLECTION OF SUCH INFORMATION AND TO THE DISCLOSURE OF SUCH INFORMATION FOR A SECONDARY PURPOSE, WHICH IS RELATED TO THE PRIMARY PURPOSE, AS OUTLINED ABOVE.

DATE:_____ NAME: _____ DOB: _____

SIGNATURE: (parent/guardian for children under 16yrs): _____