Patient Registration & Information Form

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:……..

…………………………………………………………….. **Postcode:** ………………………..

Mobile No: ……………………………………………………….. **Home No:**……………………………………………………………….

Work No: ………………………………………………………… **Email:** …………………………………………………………………………

Next of Kin: *Best person for us to contact on your behalf in the 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

Medicare Number: ……………………………………………………………………	Exp: ………../………..	Ref: ………..
Pension/Health Care Card: …………………………………………………	Exp: ………../………..	
Dept. of Veterans' Affairs: …………………………………………………..	Exp: ………../………..	

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

Do you have any **<u>allergies</u>** and / or are you **<u>sensitive to any drugs</u>** or **<u>dressings</u>**? ☐ 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 ☐ 3-4Drinks ☐ 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

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

Practice Internal Use:	Nurse__________	Doctor__________	Staff__________

MainStreet MEDICAL CENTRE AGPAL ACCREDITED GENERAL PRACTICE

Patient Registration & Information Form (continued)

How many days per week do you usually do 10 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

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

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 havebeen diagnosed with, or suffered from:

Diabetes: ☐ Yes ....

Asthma: ☐ Yes ....

Heart Disease: ☐ Yes ....

Cancer (please state type): ☐ Yes ....

Other: ☐ Yes ....

Practice Internal Use: Nurse__________ Doctor__________ Staff__________

Patient Registration & Information Form (continued)

MainStreet MEDICAL CENTRE AGPAL ACCREDITED GENERAL PRACTICE

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.

Reminder Systems:

- The practice routinely sends SMS appointment reminders to patients.

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

- Our practice provides our patients with preventative care and early case detection reminders. e.g., immunisations and pap smears.

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

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 ....

....

....

....

....

Signature of Patient/Guardian: .... Date: ....

Thank you for providing us with this information which will allow us to provide you with a high standard of medical care.

Practice Internal Use: Nurse__________ Doctor__________ Staff__________

Health Information Collection and Use Consent Form

Main Street Medical Centre

71 Main Street, Pialba, Qld, 4740

As a patient of our medical practice 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.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information.

We require your consent to collect personal information about you and to 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 healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g.,notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

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

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. 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 out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient’s name: .... **Date:** ....

Patient’s signature: ....

Signed as Guardian for child: ....

Name: (printed) ....

Practice Internal Use:	Nurse__________	Doctor__________	Staff__________