CNMC

# 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.*

***PLEASE PRINT & TICK IN ALL APPLICABLE BOXES***

| | |
|---|---|
| **TITLE** (please circle) | Mr Mrs Ms Miss Mast |
| **SURNAME** | |
| **GIVEN NAME** | Preferred Name: |
| **MIDDLE NAME** | |
| **DATE OF BIRTH** | |
| **BIRTH SEX** | ⁄⁄ Male ⁄⁄ Female |
| **GENDER IDENTIITY** | ⁄⁄ Male ⁄⁄ Female ⁄⁄ Other |
| **STREET ADDRESS** | Town/Suburb: Postcode: |
| **POSTAL ADDRESS** (if different from above) | Town/Suburb: Postcode: |
| **CULTURAL BACKGROUND** ***PLEASE TICK*** | BORN IN AUSTRALIA YES □<br>Aboriginal Yes □ - Torres Strait Islander Yes - □ Aboriginal & Torres Strait Islander Yes - □<br>Are you registered for Closing the Gap? YES □ NO □<br>Other: (e.g. Asian, African) _____<br>Country of Birth: _____ |
| **PHONE NUMBER** | Home: Mobile: |
| **EMAIL** | |
| **MEDICARE CARD NUMBER** | Ref No: EXPIRY: / |
| **DVA CARD NUMBER** | DVA GOLD □ or WHITE □ Expiry / |
| **DVA CONDITION** | |
| **PRIVATE HEALTH COVER** | YES □ NO □ FUND NAME: |
| **RELIGON** | |
| **HEAD OF FAMILY** ***FOR CHILD*** ***Reference No:1 on Medicare card*** | Name: DOB:<br>Medicare number:<br>Address (if different to patient) |
| **CONCESSION CARD NO** | Pensioner □ Health Care Card□ Expiry / / |
| **NEXT OF KIN** | Name:<br>Address:<br>Contact No: Relation to PT: |
| **EMERGENCY CONTACT** | Name:<br>Address:<br>Contact No: Relation to PT: |
| **OCCUPATION** | |

**REMINDERS: Our practice uses a reminder system to help maintain your health. The practice sends reminders by post, telephone or SMS for procedures such as vaccinations, Pap smears and other health reviews. I consent to being contacted with a reminder to help me maintain my appointments and health YES □ NO □**

**PATIENT CLINICAL INFORMATION**

NAME: _____

DOB:_____

Have you had any significant previous health problems? Yes □ No □

_____ _____

**Have you ever had or family history of:**

Diabetes ⫽ **Yes** ⫽ Mother ⫽ Father ⫽ Brother/Sister ⫽ Paternal Grandparent ⫽ Maternal Grandparent ⫽ **No**

Heart disease ⫽ **Yes** ⫽ Mother ⫽ Father ⫽ Brother/Sister ⫽ Paternal Grandparent ⫽ Maternal Grandparent ⫽ **No**

Stroke ⫽ **Yes** ⫽ Mother ⫽ Father ⫽ Brother/Sister ⫽ Paternal Grandparent ⫽ Maternal Grandparent ⫽ **No**

Asthma ⫽ **Yes** ⫽ Mother ⫽ Father ⫽ Brother/Sister ⫽ Paternal Grandparent ⫽ Maternal Grandparent ⫽ **No**

Cancer ⫽ **Yes** ⫽ Mother ⫽ Father ⫽ Brother/Sister ⫽ Paternal Grandparent ⫽ Maternal Grandparent ⫽ **No**

**If yes to cancer question, please specify what kind:** _____

Do you have any allergies or are you sensitive to any drugs or dressings: Yes □ (please list) No □

_____

**CURRENT WEIGHT _____KG CURRENT HEIGHT _____CM**

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

| **Medication** | **Strength** | **Dosage** | **Reason** |
|---|---|---|---|
| _____ | | | _____ |
| _____ | | | _____ |
| _____ | | | _____ |
| _____ | | | _____ |

**SOCIAL & LIFESTYLE HISTORY**

Alcohol: ⫽ Non-drinker ⫽ Drinker ____ number of drinks per day / week / month ***(Please circle)***

How often would you drink more than 6 drinks per day? _____

Tobacco: ⫽ Non-Smoker ⫽ Ceased Smoking _____ (year) ⫽ Smoker ____ per day / week

Do you take any other recreational substances: ⫽ No ⫽ Yes ⫽ Occasionally

Please detail _____

**When did you last have these Immunisations?**

Influenza Date:_____ Pneumococcal Date:_____ Tetanus booster Date:_____

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

## HEALTH INFORMATION COLLECTION AND USE CONSENT

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

Crows Nest Medical Centre 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, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways. Please read this consent form carefully and sign where indicated below.

- 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 through 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.

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.

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- 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 any information requested of me, but that my failure to do so might compromise the quality of my health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some cases where it might be legitimately withheld. I understand that 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 this practice for the purposes set out above, subject to any limitations on access or disclosure of which I notify the practice.
- Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

Signature of Patient or Guardian: _____ Date: ____/_____/_____

Name: _____