New Patient registration - Adult

SUNSTATE
FAMILY PRACTICE

OFFICE USE ONLY
ENTERED___________
SCANNED___________
DOCTOR ___________

PERSONAL INFORMATION					
TITLE:	SURNAME :		FIRST NAME:		
MIDDLE NAME:	PREFERRED NAME:				
Date of Birth:	Sex: ☐ Male ☐ Female ☐ Other				
I **DO** identify as ☐ Aboriginal ☐ Torres Strait Islander ☐ Both (please tick if applicable)					
What is your racial background or ethnicity? i.e Australian, English, Chinese ______________________________ With what other religion or cultural group do you identify? (if any) ______________________________ Do you require a translator/interpreter service for your appointment? ☐ Yes					
Residential Address					
Postal Address					
Phone Numbers	M:	Home:	Work:		
Contact via (best no.)	☐ Mobile ☐ Home ☐ Work				
Email address					
Please tick if you **DO NOT** wish to receive the following electronic reminders/messages via SMS ☐ Reminders ☐ Recalls and results ☐ Health Information					
☐ Please tick if you do NOT wish to have your Individual Health Identifier No. verified to enable My Health Record access					
Medicare No.		Ref No.		Expiry	
Pension Card No.				Expiry	
Health Care Card No.				Expiry	
D.V.A No.				Expiry	
Private Health	☐ Yes ☐ No				
Occupation					
Marital status					
Next of Kin (N.O.K)					
Contact No. (N.O.K)		Relationship			
Emergency Contact					
Emergency Contact No.		Relationship			
How did you first hear about our practice? ☐ Website ☐ Facebook ☐ Family or Friend ☐ Redland City Bulletin ☐ Other (please state)					

MEDICAL HISTORY		
FULL NAME:	**D.O.B.**	☐ **Nurse entered** (Initial)

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No If yes, please list below

Allergen	Reaction & severity

MEDICATIONS

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list below

Medication	Dose/Frequency	Reason

Are you taking any other medicines? (natural medicine, vitamins, herbal remedies) ☐ Yes ☐ No
If so, please list ____

PREVIOUS AND CURRENT CONDITIONS

Have you and/or any of your immediate family ever had any of the following conditions? (Please tick)

Condition	You	Family	Condition	You	Family
Arthritis			Heart Disease		
Anaemia			Heart Murmur		
Angina / Heart condition			Substance abuse		
Asthma			Hepatitis/HIV/AIDS		
Anxiety / Depression			Kidney Disease		
Dementia			Liver Disease		
High Blood Pressure			Pacemaker		
Blood Disorders			Pneumonia		
Thyroid disease			Stroke		
Cancer			Chronic Pain		
Hay fever			Diabetes		
Epilepsy			Other		

Is there any other relevant medical history not mentioned above? If yes, please list below

____

STAFF TO COMPLETE

HT: **WT:** **Waist:** **HR:** **BP:**

SURGICAL HISTORY

Do you have a history of surgical procedures? ☐ Yes ☐ No If yes, please list below

Procedure	Date and location performed

RISK FACTORS

Are you a smoker?

→ If yes, how many do you smoke per day? ______

Are you an Ex-smoker? ☐ Yes ☐ No

→ When did you quit? _________

How many days a week do you drink alcohol? (Please circle)

→ 0 1 2 3 4 5 6 7

How many standard drinks do you drink per day? (Please circle)

→ 0 1 2 3 4 5 6 7 more

IMMUNISATION HISTORY

Influenza	Date vaccinated	
Tetanus	Date vaccinated	
Whooping cough	Date vaccinated	
Meningococcal ACWY (15-19yrs)	Date vaccinated	
Measles/Mumps/Rubella (Born during or after 1966)	Date vaccinated	

SKIN CHECK HISTORY

When was your most recent skin check?________________ ☐ Never had a skin check

Name of clinic where most recent skin check performed ______________________________________

FOR PATIENTS 65 AND OVER ONLY

Have you ever had a Health Assessment? (75 +yrs)	☐ Yes ☐ No
Have you had your Pneumococcal vaccination?	☐ Yes ☐ No
Have you had your shingles vaccination? (70 -79yr old)	☐ Yes ☐ No

FOR FEMALE PATIENTS ONLY

Have you ever been pregnant?	☐ Yes ☐ No
→ Number of pregnancies?	
→ Number of children?	
Have you ever had a cervical screening?	☐ Yes ☐ No
→ When was your last screening?	
→ Have there ever been abnormal results?	

HEALTH INFORMATION COLLECTION AND USE CONSENT

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health 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 and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons e.g. General Practice Managers.
- 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.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

I acknowledge there may be a need to contact me, & I permit the use of the telephone numbers provided by me. By providing these contact numbers, I accept that a message may be left with the person answering these numbers, or on a message service attached to these numbers.

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.

Patient Name: ________________________________ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health 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.
Signature: _________________________ Date: _________________________________
If not Patient signing – Your Name (Please Print)________________________________
Your relationship to patient (e.g. Mother, Father, guardian)________________________