Patient Registration Form

vitality healthcare MEDICAL CENTRE

Please use BLOCK letters to fill

Title ❑ Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Mast ❑ Dr

Patient Name | Given name | Family name | Preferred name

Date of Birth D M Y **Sex** **Occupation**

Ethnicity To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

❑ Aboriginal ❑ Torres Strait Islander

❑ No, other cultural background (eg. Chinese, Italian, Indian)

Please state: **Country of Birth**

Preferred Language **Interpreter required?** ❑ No ❑ Yes

Address **Home Phone**

Suburb **Postcode** **Work Phone**

Email **Mobile Phone**

Medicare No. **Reference No.** **Expiry Date**

Concession Card ❑ No ❑ Yes, please provide details below

❑ Health Care Card **Expiry Date**

❑ Pensioner Card **Expiry Date**

❑ DVA Card **Expiry Date**

Health Insurance Fund **Membership No.**

Parent/ Guardian (if patient is under 18 years of age, a parent/ guardian is to fill out the details below)

Head of family | Given name | Family name | Preferred name

Date of Birth D M Y **Sex** **Phone**

Medicare No. **Reference No.** **Expiry Date**

Next of Kin Contact

Given Name **Family Name**

Relationship **Phone**

Emergency Contact

Given Name **Family Name**

Relationship **Phone**

Smoker Status ❑ Smoker, if so, how many cigarettes per day ❑ Non-Smoker ❑ Ex-Smoker

Alcohol Status ❑ Non-drinker ❑ Social-drinker ❑ Heavy-drinker

Allergies Do you have any allergies or sensativities to drugs or dressings?

❑ No ❑ Yes, please provide details

Height **Weight**

Current Medications (including complementary, over-the-counter medicines, supplements & vitamins)

Medical History ❑ Asthma ❑ Diabetes ❑ Hypertension ❑ Chronic Illness ❑ Heart Disease ❑ Mental Illness

❑ Other Significant - provide details

Family History

Patient Consent

Please read this consent form carefully prior to signing.

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.

Also by signing below, you, _____

- have read the information above and understand the reasons why your information must be collected, and the purposes for which your information may be used or disclosed. You understand that if your information is to be used for any purpose other than that set out above, your further consent will be obtained.
- give permission for your personal information to be collected, used and disclosed as described above, including contact via SMS to your mobile phone number. You understand only your relevant personal information will be provided to allow the above actions to be undertaken and you are free to withdraw, alter or restrict your consent at any time by notifying this practice in writing.
- are aware of the non-attendence policy of our practice that fees will be applied to your account per appointment which is not attended, rescheduled or cancelled according to the latest non-attendence and cancellation policy. This fee will need to be paid before you make your next appointment booking.
- are consented to Vitality Healthcare Medical Centre to lodge Medicare Claims for all medical visits on your behalf. (only applicable to Medicare card holder)

Patient's Name (Please Print)

Signature

Date

If Not Patient Signing, Your Name (Please Print)

Your Relationship To Patient (e.g. Mother, Father, Guardian)