Patient Registration & Information Form

A: 194 Durlacher St, Geraldton WA 6530
A: PO Box 7218, Geraldton WA 6530
E: admin@cityhealthgeraldton.com.au
P: 08 9921 4433 F: 08 9965 5380
ABN: 65 515 953 825

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

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 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 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 the practice.	☐

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: ……

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Name: (printed) .....

PATIENT TO COMPLETE

Family Name: ..... **Given Names:** .....

Preferred Name: ..... **DOB:** ...../...../.....

Sex: M ☐ F ☐ Other ☐ ..... **Title:** Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Address: .....

Suburb: ..... **Post Code:** .....

Postal Address: .....

Suburb: ..... **Post Code:** .....

Mobile Phone: ..... Do you wish to **OPT OUT** of our SMS service? ☐

Home Phone: ..... **Work Phone:** .....

Email: .....@.....com

Current Occupation: ..... **OR Retired Occupation:** .....

Medicare Card ..... **Ref** ..... **Expiry** .....

Pension Card ..... **Expiry** .....

DVA Number ..... **Expiry** ..... **Specific / All**

Next of Kin

Your MAIN guardian if something happens to you.

Full Name: ..... Phone Number: .....

Relation to you: .....

Emergency Contact

Someone CLOSE who can contact or help you if needed, other than Next of Kin.

Full Name: ..... Phone Number: .....

Relation to you: .....

Do you identify as Aboriginal or Torres Strait Islander? ☐ YES ☐ NO

Country of Birth: ..... Language spoken at home: .....

Have you consented to My Health Record? ☐ YES ☐ NO

If so, do you consent for us to upload your information? ☐ YES ☐ NO

Are you transferring from another practice? ☐ YES ☐ NO

Have you already organised your records to be Transferred? ☐ YES ☐ NO

If so, which medical practice?

Dr.....

Practice .....

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Do you have any specialists involved in your care? If so, please name: ……

……

DOCTOR/ NURSE TO REVIEW

Current Medications: ……

……

Do you have any **allergies** and / or are you **sensitive to any drugs or dressings?**

……

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

Last Podiatry visit …… Last eye check: …… Last spirometry: ……

When was your last Well Woman or Well Man check? ……

When was your last Skin Cancer Screening? ……

Family History

Please list any member of your family who have been diagnosed with:

Diabetes: ☐ Yes ……

Asthma: ☐ Yes ……

Heart Disease: ☐ Yes ……

Cancer: ☐ Yes ……

Mental health Issues: ☐ Yes ……

Any other significant medical diagnoses? ……

Smoking

☐ Never Smoked ☐ Ceased smoking in …… ☐ Smoker …….. Daily/Weekly

Alcohol

Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many standard drinks do you have a day ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often would you drink more than 6 drinks/day ☐ Never ☐ Less than monthly ☐ Monthly

☐ Weekly ☐ Daily Are you worried about your drinking? ☐ YES ☐ NO

Height: ……cms Weight: ……kg Waist Measurement: ……cms

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Past Operations

Date: …… Details: ……

Date: …… Details: ……

Date: …… Details: ……

Pap Smear Date: …….. ☐ Not Sure ☐ Never

Breast Check Date: …….. ☐ Not Sure ☐ Never

Mammogram Date: …….. ☐ Not Sure ☐ Never

If 50 years or older, have you had a test as part of the National bowel Cancer Screening Program?

☐ Yes ☐ No

Do you have an Advanced Health Directive? ☐ Yes ☐ No

What practice did you previously attend? ……

Dr:……

Do you wish to transfer to this practice? YES ☐ NO ☐

The request to transfer is on the final page.

If you wish to transfer to this practice, please be aware fees may apply

Additional Notes:

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Request for Medical Records

The mentioned now attends this practice. To assist in their future medical management would you kindly forward any clinical records or accurate health summary.

DATE OF BIRTH	FIRST NAME	SURNAME

Place where records are held

PRACTICE	DOCTOR	CONTACT

Please forward records via email in XML format if from Medical Director or in PDF format for other software
or alternatively via fax
E: admin@cityhealthgeraldton.com.au
F: 08 99655380

Patient sign: _____
(If under 18 years Guardian please sign
Date: _____