Montrose Medical Practice

New Patient Registration Form

Demographic Information

Title ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐Other ....

Given names

Surname

Signature (for identification purposes)

Date of Birth / / Sex ☐Male ☐Female ☐Other

Are you of Aboriginal or TSI background? ☐Yes ☐No

If yes, ☐Aboriginal ☐TSI **or** ☐Both Aboriginal and TSI

Medicare number (10 digits)

Your number on card Expiry date /

☐Health care card (Centrelink) **or** ☐Pensioner card details:

Card number Expiry date / /

DVA no (if applicable) ☐Gold ☐White

Street address

Suburb **Post code**

Home phone

Work phone

Mobile phone

☐Tick if you do **not** want us to send you SMS reminders

Email

Marital status ☐Single ☐Married ☐De facto ☐Other........

Occupation

Student ID (if Full Time) Expiry date

Country of birth ☐Australia ☐Other ....

Languages spoken ☐English ☐Other ....

Emergency contact person

Phone no Relationship

How did you hear about our practice?

OPTIONAL Medical Information

Do you have any allergies? ☐No ☐Yes, please specify

Any medication e.g. contraception? ☐No ☐Yes, please specify

Any medical history e.g. asthma? ☐No ☐Yes, please specify

Any family history e.g. diabetes, heart disease, stroke,

bowel cancer, breast cancer? ☐No ☐Yes, please specify

Who lives with you?

Do you smoke? ☐Smoker ☐Ex-smoker ☐Never smoked

Number of cigarettes per day?

Year started smoking? Quit date?

How often do you drink alcohol? ☐Everyday

☐5-6 days a week ☐3-4 days a week ☐1-2 days a week

☐1-2 days a month ☐< monthly ☐Never

On a day you drink alcohol, how many standard drinks?

When was your last screening blood test?

Last pap smear Result

Last mammogram Result

Patient Consent for use of Personal Health Information

Within the Practice

I __________________________ give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want my medical or personal information disclosed to other doctors or staff of this practice I need to inform my usual doctor of this issue.

Outside the Practice

Furthermore, I agree to allow my doctor to communicate relevant medical details to Specialist Doctors, Hospital Medical Staff, Pathology labs and other Health Care Providers e.g. Physiotherapists, Podiatrists etc involved in my medical care.

This practice from time to time participates in Medical Research projects with outside organisations. We stress that all information shared is ***depersonalised*** (i.e. names of patients are not given).

If you DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box ☐

For Dependant

As Parent/Guardian of the above named patient, I authorise that their health information be also used in the above mentioned manner.

Your Signature -Patient/Parent/Guardian:

____

Date: