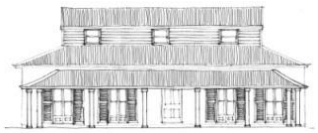
Montrose Medical Practice

New Patient Registration Form



ALL BOLD FIELDS ARE COMPULSORY
Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐ **Dr**
Given Name/s
Surname
Preferred Name:
Date of Birth / /
Birth Sex ☐ Male ☐ Female ☐ Intersex **Gender Identity** ☐ Male ☐ Female ☐ Non-binary ☐ Other _____ **Preferred Pronouns** ☐ She/Her ☐ He/Him ☐ They/Them
Ethnicity Are you of Aboriginal or TSI background? ☐ Yes ☐ No If yes, ☐ Aboriginal ☐ TSI **or** ☐ Both Aboriginal and TSI If no, ☐ Other Ethnicity_____ Languages spoken ☐ English ☐ Other _____
Medicare Number (10 digits) __ __ __ __ __ __ __ __ __ __ __ **Your Number on Card (1, 2, 3 etc.)** __ **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**
Mobile Phone
Email
Occupation
Marital status ☐ Single ☐ Married ☐ De facto ☐ Other _____
Who lives with you?
Student ID (if Full Time) Expiry date / /
Emergency Contact Full Name
Phone Number
Relationship
How did you hear about us?

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/breast cancer?
☐ No ☐ Yes, please specify:
Do you smoke? ☐ No ☐ Yes
Number of cigarettes per day?
Year started? Quit date?
Do you vape? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes
How often?
How many drinks on average?
Last Health Screening? e.g. Cervical Screening, Mammogram, FOBT, Skin Check
Please specify:

This page is double sided, please finish both sides before handing back to reception **Last updated: 21/02/2024**

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. ☐_____ (Initial)

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.

Occasionally, the practice will supply depersonalised patient information for medical research projects or accreditation purposes. We ensure that this information is de-identified. If you wish to opt-out of these research programmes, please let your General Practitioner know.

If you CONSENT to your de-identified information being used in this manner, please indicate with a cross in the following box: ☐_____ (Initial)

Email Policy

Montrose Medical Practice extends the option for patients to engage in communication through email. Your email address will never be provided to a third-party unless your specific consent is given in writing. Personalised information will only be emailed with your consent by signing the agreement or verbal consent is given to your doctor. All consent communication will be recorded in your patient file. If you would like to read a copy of our full email policy, please ask our friendly reception staff. You may opt out of email communication at any time by speaking to your doctor or our reception staff.

It is important to acknowledge that transmitting patient information via email inherently carries risks. While we cannot guarantee the absolute security of email communication, Montrose Medical Practice is committed to employing reasonable measures to safeguard the security and confidentiality of information transmitted via email.

By signing this form, you grant consent for the release of your medical information/records through email and fully understanding the associated risks tied to communication through email. Additionally, you are granting permission for your doctor to share relevant medical information with Specialist Doctors, Hospital Medical Staff, Pathology labs, and other Health Care Providers (e.g., Physiotherapists, Podiatrists etc.) involved in your healthcare through email.

Please tick if you CONSENT to email correspondence ☐_____ (Initial)

For Dependants

As Parent/Guardian of the above-named patient, I authorise that their health information also be used in the above-mentioned manner. ☐_____ (Initial)

Patient Signature (Parent/Guardian if applicable):

X _____ **Date:** _____