**Patient Registration Form**

Please fill out this form to ensure that we can provide you with best quality care and can keep your health records accurate and up-to-date. If you have any concerns, or are unsure about any questions, leave them blank and you can discuss these with your doctor at your next appointment.

Complete and return this form to the above address, or email to [reception@balmed.com.au](mailto:reception@balmed.com.au?subject=Patient%20registration%20form).

Title: Mr Mrs Ms Miss Master Dr Other

First Name: First name . Surname: Family name

Preferred Name: Preferred name Date of Birth: Date of birth

Street Address: Street address

Suburb:Suburb Postcode: Postcode

Postal Address (if different from above)

PO Box/Street: PO box or street address

Suburb: Suburb Postcode: Postcode

Mobile No: Mobile number Home phone: Home phone

Work phone: Work phone Email Address: Email address

Medicare number: Medicare number Ref: Ref # Expiry date: Expiry M/Y

Pension/ Health Care Card: Pensioner/health card number Expiry date: Expiry M/Y

Dept. of Veterans’ Affairs: DVA card number Expiry date: Expiry M/Y

Please present cards to staff so they can confirm details on our system.

To assist with health initiatives, are you Aboriginal or Torres Strait Islander? Yes No

Aboriginal  Torres Strait Islander  Aboriginal & Torres Strait Islander

Do you authorise the practice to send you SMS appointment confirmations? Yes No

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and cervical screening tests.

Do you wish to have any relevant reminders sent to you? Yes No

If we need to contact you, what is your preferred method of contact?

Home phone  Mobile Phone  Email  Mail

Who can we contact in an emergency? Next of Kin/Emergency Contact Details.

First Name: Next of kin first name Surname: Next of kin family name tap

Phone No: Next of kin phone number Relationship: Relationship to next of kin

**Medical history**

Do you have any previous illnesses or medical conditions we need to be aware of? (tick below or list)

High blood pressure

Bleeding tendency

Hepatitis

Deep vein thrombosis

Heart valve surgery

Angina or heart disease

Diabetes

Stomach Ulcer

Asthma

Skin cancer surgery

Varicose Veins

Currently pregnant

HIV

Other – provide relevant details below

Other relevant details

**Current medications**

Please list medications below (including over the counter medications, vitamins and minerals)

Current medication details

**Allergies**

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

Yes (please list below)  No

Details of allergies

**Lifestyle history**

Alcohol

I am a non-drinker (never drink alcohol).

I drink alcohol

* How often do you have a drink containing alcohol?

Monthly or less  2-4 times per month  2-3 times a week  4+ times a week

* How many standard drinks containing alcohol would you have on a typical drinking day?

1-2 drinks  3-4 drinks  5-6 drinks  7-9 drinks  10+ drinks

* How often would you consume 6 or more drinks on one occasion?

Never  Less than monthly  Monthly  Weekly  Daily or almost daily

* Are you concerned about your drinking?

Yes  No

Tobacco

I have never smoked  I am an ex-smoker, quit date/year: Date

I am a smoker, number/ amount Number per  day or  week

**Your Health Information**

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the [Australian Privacy Principles](https://www.oaic.gov.au/privacy/australian-privacy-principles/read-the-australian-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 GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
* For legal related disclosures as required by Court of Law;
* For the purposes of research 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.

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.

I, Your name , give my permission for my personal health information to be collected, used and disclosed 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 to restrict my consent at any time by notifying this practice in writing.

Patient name (please print): Patient’s full name

Signature: By checking this box, I confirm that the information on this form is true and correct.

Date: Date

Are you the patient on this form?  Yes  No.

If no, what is your name? Your name Relationship to patient? Relationship to patient