BALNARRING MEDICAL CENTRE 50 Balnarring Road, Balnarring, Victoria, 3926
Tel: 5983 1355 Fax: 5983 2321

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 or by email to reception@balmed.com.au

CONTACT DETAILS: Title: ☐ Mr, ☐ Mrs, ☐ Ms, ☐ Miss, ☐ Master, ☐ Dr, ☐ Other ________

First Name: ____________ **Surname:** ______________ **Preferred Name:** _______________

DOB: ___/___/___ **Gender:** ☐ Male ☐ Female ☐ Other_________________

Address: _______________________________ **Suburb:** ______________ **Postcode:**______

Postal Address: _________________________ **Suburb:** ____________ **Postcode:**_______

Contact Numbers; Mobile: _________________ **Home:** ____________ **Work:** __________

Email Address: ___________________________________ **Occupation:** ________________

Medicare No: _________________________ **Ref No:**_____ **Expiry Date:**________

Vet affairs No: _________________________ **Ref No:**_____ **Expiry Date:**________

Pension/Health Care Card No: ________________________ **Expiry Date:**________

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

If patient is a minor, who is responsible for the account?

First Name: ____________ **Surname:** _______________ **Relationship to Patient:** ________

Contact Numbers: Home: _____________ **Work:** ____________ **Mobile:** _____________

NEXT OF KIN:

First Name: ____________ **Surname:** ____________ **Relationship to Patient:** _________

Contact Numbers: Home: _____________ **Work:** _____________ **Mobile:** ____________

EMERGENCY CONTACT:

First Name: ____________ **Surname:** ____________ **Relationship to Patient:** ___________

Contact Numbers: Home: _____________ **Work:** _____________ **Mobile:** ____________

Are you Aboriginal or Torres Strait Islander: **YES** ☐ **NO** ☐

Were you born in Australia: **YES** ☐ **NO** ☐ If no, your country of birth: ___________________

MEDICAL HISTORY:

Do you have any previous illnesses or medical conditions? (tick below or list)

☐ High blood pressure ☐ Angina or heart disease ☐ Varicose Veins
☐ Bleeding tendency ☐ Diabetes ☐ Currently pregnant
☐ Hepatitis ☐ Stomach Ulcer ☐ HIV
☐ Deep vein thrombosis ☐ Asthma ☐ Other ______________
☐ Heart valve surgery ☐ Skin cancer surgery

Current medications

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

____

____

ALLERGIES:

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

☐ **YES** (If yes, please list below) ☐ **NO**

____

LIFESTYLE AND SOCIAL 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 _______

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

PREFERRED CONTACT METHOD:

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 ☐ Mail

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, 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, ____________________________, give 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.

Signature:________________________________ Date: ________________________________

If you are not the patient signing, please print your name: ______________________________