Part 1 of 3

New Patient Registration Form

Title: Mr / Mrs / Ms / Miss/ Master / Dr / Prof / other: _____

Gender: ☐ Male ☐ Female ☐ Intersex/Other ☐ Transgender ☐ Not Stated

First Name: _____ **Surname:** _____ **Previous Surname:** _____

Known As: _____**Date of Birth**____ /____/____ **Insurance** ☐ Nepal ☐ Foreign ☐ Neither

Are You: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

PLEASE SELECT ONE:

Cultural & Ethnic Background: ☐ Nepalese ☐ Other: _____

Country of Birth: ☐ Nepal ☐ Other: _____ **If Born Overseas, Year of Arrival to Nepal:** _____

Preferred Language: _____

Referred BY: __ __ __ __ __ __ __ __ __ __ __ __

Address: _____

_____

Home Phone Number: _____ **Work Phone Number:**

_____ **Mobile Number:** _____

Email Address: _____ **Occupation:** _____

Person to contact in Emergency: _____

PARENT /GUARDIAN (if patient is a child under 16):

MOTHER'S Name: _____**Profession:** _____**Mobile No.**_____

FATHER'S Name: _____**Profession:** _____**Mobile No.**_____

NEXT OF KIN : ☐ **Same as Parent/Guardian, or:**

First Name: _____ **Surname:** _____ **Known as:** _____

Phone Number: _____ **Relationship to Patient:**_____

_____

_____

How did you hear of us? ☐ Recommendation ☐ Passing by ☐ Other doctor
☐ Google ☐ Word of Mouth ……

Part 2 of 3 **Consent Form** **Page 2 of 4**

Please read this consent form carefully, and sign where indicated below.

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 of your health information. We require your consent to collect your personal information, and for its use in the following ways:

- Administrative purposes.
- Billing purposes (including compliance with Medicare and Health Insurance requirements).
- Disclosure to others involved in your healthcare. This includes your treating doctor and specialists outside this medical practice. This may occur though referrals 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 for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Only information that does not identify you is used in these circumstances.
- To comply with any legislative or regulatory requirements of Nepal Public Health Department (J*ana Swastha Mahasakha*) , such as notifiable diseases.
- For reminders and recalls which may be sent to you regarding your health care and management.

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 and 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 that 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 this practice.

I consent to SMS text message appointment reminders/ notifications be sent to my mobile phone.

I consent to email reminders/ notifications to be sent to me.

or alternatively, I am unsure whether to these consents and would I like to discuss this further with someone from the medical practice before I decide to sign. ☐

Patient Name: …… **Date :** ...../……../20……

Patient Signature: ……..……..

Signed as Guardian for Child: ……..……

Name of Guardian: (PRINTED)…….....

Allergies:

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

☐ **No**. ☐ **Yes**. Please elaborate:

Drug, Dressing or Substance	Reaction (e.g. rash, hives, wheeze, shortness of breath, anaphylaxis)

Smokes & Vapes:

☐ **Never smoked**
☐ **Ex-smoker** (Please answer questions below)
☐ **Smoker** (Please answer questions below)
Year when you started smoking? ……..
Year when you ceased smoking? ……... or ☐ **Currently smoking.**
Longest period of abstinence whilst smoking? …….. years / months / weeks / days
Frequency: ☐ Daily ☐ Weekly ☐ Less than weekly
Number of cigarettes when you do/did smoke? …… per day **or** ……..… per week

Alcohol:

☐ **Never**
☐ **Yes:** **Frequency?**
☐ Less than monthly
☐ Monthly
☐ 2-4 times a week
☐ 2-3 days per week
☐ 3-4 days per week
☐ 4 or more days per week
☐ Daily

On a day that you drink, how many standard drinks do you have? 1 / 2 / 3 / 4 / 5 / 6 / other: ……
How often do you drink 6 or more standard glasses of alcohol in one day?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Other Drugs:

☐ **No**
☐ **Yes** Type (Please circle): Cannabis / Methamphetamine / Ecstasy / LSD / Cocaine / Heroin
Other: ..... Frequency: ……..

Family History:

Have any family members (other than yourself) had any of the following medical problems?
If yes, please tick the box and please elaborate:

☐ High Blood Pressure ……
☐ High Cholesterol ……
☐ Diabetes ……
☐ Thyroid Disease ……
☐ Heart Disease ……
☐ Stroke ……
☐ DVT or Lung Clots ……
☐ Cancers ……
☐ Melanoma ……
☐ Skin Cancer ……
☐ Osteoporosis ……
☐ Varicose Veins ……
☐ Migraines ……
☐ Mental Illness ……
Other: ……
……
……
……

Past Medical History:

Do you have or have you had a history of the following? (Please elaborate)

☐ Surgeries ……

☐ Asthma ……

☐ Diabetes ……

☐ High Blood Pressure ……

☐ Chronic Illness ……

☐ Other ……

……

Current Medications :

Please list all current medications, doses and frequency of use including over the counter medications, vitamins and minerals: ……

……

……

……

Females:

When did you last have?

Cervical Screening Test:	Date: ……../……../……..	☐ Not sure ☐ Never
Breast Check:	Date: ……../……../……..	☐ Not sure ☐ Never
Mammogram:	Date: ……../……../……..	☐ Not sure ☐ Never
Bone Mineral Density Scan:	Date: ……../……../……..	☐ Not sure ☐ Never

Males:

When did you last have an overall checkup: Date: ……../……../…….. ☐ Not sure ☐ Never

For those 65 years and older:

When was the last time you were immunised?

Influenza: Date: ……../……../…….. ☐ Not sure ☐ Never

Pneumococcal pneumonia: Date: ……../……../…….. ☐ Not sure ☐ Never

Immunisations:

If completing this form for a child: **Are their immunisations up to date? ☐ Yes ☐ No**

Have you had the following immunisations? (List the date where appropriate)

POLIO/ DTaP/Tdap/ Booster	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Rotavirus	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Hepatitis A/ Hepatitis B	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Typhoid	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Influenza	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Pneumococcal	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Rabies	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Measles, Mumps, Rubella	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Japanese Encephalitis	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Yellow Fever	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Meningococcal	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
HPV	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.
Shingrix / Varicella	☐ Yes. Date: ..../..../……..	☐ No.	☐ Don't know.

Consent for Immunization:

Kopila offers various immunization for children and adult against diseases as per immunization schedule recommended by CDC (USA) and EPI, WHO for Nepal. It is advisable to increase your immunity against these life threatening diseases.

I CONSENT TO RECEIVING IMMUNIZATION FOR ANY OF THE MISSIING VACCINES LISTED ABOVE.

Signature