GRAND HEALTH MEDICAL CENTRE

New Patient Registration Form

PLEASE PRINT CLEARLY AND COVER ALL SECTIONS			
Title:	Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss ☐ Other: _____		
Birth Gender:	**Gender Identity:**		
Surname:			
First Name:		**Preferred Name:**	
Middle Name(s):			
Date Of Birth:	__ __ / __ __ / __ __ __ __		
Status:	Single/married/Defacto/Separated/Widowed		
Street Address:			
Suburb:		**Postcode: __ __ __ __**	
Postal Address:			
Mobile:		**Home Phone:**	
Email Address:		**Occupation:**	
Do you have any allergies? YES ☐ NO ☐ If yes, what are you allergic to? _____ Reaction: _____			
Medicare Number:	__ __ __ __ __ __ __ __ __ __ **Ref:** __	**Expiry Date: __ __ / 20 __ __**	
Pension Card ☐ Health Care Card ☐	*No:* __ __ __ __ __ __ __ __ __ __	**Expiry Date: __ __ / __ __ / __ __ __ __**	
DVA Card No: __ __ __ __ __ __	**Expiry Date __ __ / __ __**	**White ☐** **Gold ☐**	
Do you have private health insurance? No ☐ Yes ☐ Provider: If yes, what is your health fund number:			
ETHNICITY/ CULTURAL BACKGROUND: Aboriginal ☐ Torres Strait Islander ☐ Others ☐ *(e.g. Australian, Italian, Chinese etc.)* _____			
Next of Kin *(spouse or closest living relative)*	**Full Name:**	**Relationship:**	
	Phone:	**Alternative number:**	
Emergency Contact *(only to be contacted in emergencies when we cannot contact you or your next of kin)*	**Full Name:**	**Relationship:**	
	Phone:	**Alternative number:**	

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PAST MEDICAL HISTORY		
Alcohol:	**YES ☐ NO ☐** **Standard Drinks per Day _____**	Weight: _____kg
Smoking:	**YES ☐ NO ☐** **Quantity per Day _____**	Height: _____cm

Please tick all the relevant conditions

- ☐ Deep venous thrombosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gynaecological problem/ continence issues
- ☐ Gastrointestinal disorders
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Asthma / Respiratory Disease
- ☐ Thyroid Disorders
- ☐ Other _____
  _____

FAMILY HISTORY

	Mother	Father
☐ Cancer	☐	☐
☐ Diabetes	☐	☐
☐ Heart Disease	☐	☐
☐ High Blood Pressure	☐	☐
☐ Other	☐	☐
_____	_____	_____
_____	_____	_____

Terms & Conditions for your safety and others

1. We have zero tolerance to violent, disruptive or inappropriate behaviours. Instant termination of service from Grand Health Medical Centre will be applied and police will be involved and person with above behaviours will be prosecuted.

2. Without any strong medical indication (e.g. Broken bone) and proper medical records and confirmation from your regular doctor involved in your care, the following medications cannot be prescribed:

   a. Any opioids or other addictive medication (Panadeine Forte, Endone, Tramadol, etc.)
   b. Benzodiazepine (Diazepam, Valium, etc.)
   c. Anti – Psychotic Medication (Seroquel, Olanzapine, etc.)
   d. Neuropathic Medication (Lyrica, Pregabalin, etc.)

If approved, above prescription will be a temporary prescription only. You will be referred to your regular doctor.

Signature:_____ **Date: __ __ / __ __ / 20 __ __**

HOW DID YOU HEAR ABOUT US:

☐ letter box distribution ☐ word of mouth ☐ website ☐ facebook ☐ other _____

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Collection, use & disclosure of your information – Please read carefully before signing

Grand Health Medical Centre recognises that the information we collect is often of a highly sensitive nature and as an organisation, we have adopted the privacy compliance standards relevant to Grand Health Medical Centre to ensure personal information is protected. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 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 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, parent or guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall and appointment reminders, issued by post or SMS (you will be automatically opted in to SMS reminders, if you wish to opt out please advise our reception staff).
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- To comply with any legislative or regulatory requirements, e.g. mandatory reporting of notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

Grand Health Medical Centre will employ all reasonable endeavours to ensure that a patient's personal information is not disclosed without their prior consent.

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. Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

Our full privacy policy brochure is available on request.

I, _____ have read the information in the above patient consent form and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

Signature: _____ Date: _____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian) _____