NEW PATIENT REGISTRATION FORM

We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate. Please assist us by completing the following and once completed please return to reception.

Surname:			
First Name:		MR MRS MS DR MASTER MISS	
Date Of Birth:			
Medicare Number:	_ _ _ _ _ _ _ _ _ _	Patient No. _	Expiry Date: _ _/_ _ _ _
DVA (Dept of Veteran Affairs):	Gold/White (Please Circle)		Card No: _____
Home Address:		Postal Address:	
Contact Number	Home:	Mobile: Consent to SMS Reminders □	Work:
Email Address:			
Occupation:			
Nationality:			
Do you identify as Aboriginal or Torres Strait Islander?		Aboriginal □ Torres Strait Islander □ Are you registered for Closing The Gap? Yes / No NCACCH no:	
(Please Tick) Pensioner Concession Card □ Health Care Card □ Commonwealth Seniors Health Card □		Concession Number: Expiry Date:	
Private Health Cover:	Fund:	Membership No:	
Emergency Contact:	Name: Phone:	Relationship: Consent to Contact: Yes / No	
If a CHILD please give parents names:	Mother: Phone:	Father: Phone:	

I consent to Better Health on Buderim contacting me for follow up of results or reminder notices for preventative care. Our doctors currently send scripts electronically and will have access to your history of any prescribed or dispensed prescriptions. Please advise the doctor if you do not consent to this.

Signature: _____ Date: _____

BETTER HEALTH ON BUDERIM
Medical Centre

HEALTH HISTORY FORM

We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate. Please assist us by completing the following. Once completed please give to your doctor.

Surname		
First Name:		MR MRS MS DR MASTER MISS
Date of Birth:		

Your HEALTH History – Do you have or had a history of?

□ Operations □ High Blood Pressure □ Asthma □ Epilepsy □ Diabetes

□ Any other major health or illness? (Please use the space below):

_____

_____

Your SOCIAL History?

Marital Status _____

Sexuality: □ Heterosexual □ Homosexual □ Bisexual

Accommodation: □ Lives Independently □ Nursing Home □ Other

Live with: □ Spouse □ Relative □ Friend □ Other

Do you have any ALLERGIES or are you SENSITIVE to DRUGS or DRESSINGS?

□ Yes (If yes please list below) □ No

_____

_____

IMMUNISATIONS – Have you had the following immunisations?

Tetanus booster	date_____	□ Don't Know	□ Haven't had one
Hepatitis B or A	date_____	□ Don't Know	□ Haven't had one
Influenza	date_____	□ Don't Know	□ Haven't had one
Pneumococcal	date_____	□ Don't Know	□ Haven't had one
Polio	date_____	□ Don't Know	□ Haven't had one

Children's Immunisations - If completing this form for a child are their immunisations up to date?

□ Yes □ No □ Don't Know

Current MEDICATIONS (including over the counter medications, vitamins and minerals)

_____

_____

Do you SMOKE, DRINK, or use other drugs?

□ Tobacco: _____ day/week Ceased Smoking – date _____

□ Alcohol: _____ day/week/month (circle the one applicable)

□ Drug use: _____ (type and how often used?)

FAMILY MEDICAL HISTORY – Have any of your family had?

□ Diabetes □ Mental illness □ Asthma □ Heart Disease

□ Cancer (e.g. Bowel, Prostate, Breast, Melanoma?) □ Other? _____

For Females:	**When did you last have?**		
Pap Smear	Date _____	□ Not Sure	□ Never
Mammogram	Date _____	□ Not Sure	□ Never

For Males:	**When did you last have?**		
An overall check-up	Date _____	□ Not Sure	□ Never

Dear Patient,

This general practice collects information from you for the primary purpose of providing quality health care. 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; we will 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 may include, but not limited to: 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/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 notices for treatment and preventative healthcare, frequently issued by SMS.
- 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.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- 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.

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.

Consent

I, _____ have read the information above 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.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____ Date: _____

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

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

PRACTICE USE ONLY:

Witnessed by: (staff signature)_____