NARANGBA STATION
MEDICAL CENTRE

New Patient Registration Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate. All new patients are asked to complete the following.

Title: _____ Given Name(s): _____ Surname: _____

Date of Birth: ____/____/____

Address: _____

_____ Suburb _____ Postcode: _____

Postal Address if different to above: _____

_____

Daytime phone: _____ Mobile: _____ Work: _____

Email address: _____

Occupation: _____

Next of Kin Name: _____ Relationship: _____

Daytime phone: _____ Mobile: _____

Date of Birth: ____/____/____

Emergency Contact: ☐ As above (it's advisable to have a different emergency contact to the next of kin nominated)

Name: _____ Relationship: _____

Daytime phone: _____ Mobile: _____

Date of Birth: ____/____/____

If a CHILD, please give parents names

Mother: _____ Date of Birth: ____/____/____

Daytime phone: _____ Mobile: _____

Father: _____ Date of Birth: ____/____/____

Daytime phone: _____ Mobile: _____

To whom should the account be addressed if the patient is a child:

Name: _____ Date of Birth: ____/_____

Private Health Cover: Fund:_____ Member no:_____

Medicare number: _____

Reference number (next to name):_____ Card expiry: ____/____

Pension or centre link HCC:_____ Card expiry:____/____

DVA number: _____ Card expiry: ____/____

Gold / White If white accepted conditions: _____

Full time student Card number:_____ Card expiry: ____/____

Ethnicity: ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander

How did you hear about us?

☐ Google ☐ Facebook ☐ Family/friend recommendation Other : _____

Please hand this page to Reception. The rest to be given to your doctor.

Are you sensitive to any dressings?: _____

Allergies: ☐ Nil known

Allergy/Intolerances:	Reaction:	Severity:

Please tick any relevant past medical/surgical history:

Conditions:	Details:	Year:
☐ Heart Disease ☐ High Blood Pressure ☐ High cholesterol ☐ Diabetes ☐ Cancer ☐ Migraine ☐ Stroke ☐ Blood clots ☐ Asthma ☐ Stomach or duodenal ulcer ☐ Epilepsy ☐ Depression / Anxiety		

Past operations/ Surgery you have had in the past – please give details

Date/year:	Details:

Any other major health event or illness:

_____

Please list current medications, including vitamins and mineral supplements:

Name:	Dose:

Immunisations:

Are your childhood immunisations up to date? YES / NO

Please state if you had any of the following immunisations:	YES	NO	If no, tick if you would like us to organise.
Tetanus			
Hepatitis A			
Hepatitis B			
Influenza			
Pneumococcal vaccine (for over65 years old)			
Shingles vaccine or Shinrix (If you are between 50and 79 years old)			
Gardasil (1,2 and 3)			
Polio			
Measles			

Any other relevant immunisations: _____

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

YES / NO / Dont know

Infant / child profile Please list any problems during pregnancy: _____

_____

When was the baby/child born?: ☐ Full Term Premature – how many weeks?: _____

Mode of delivery: ☐ Normal ☐ Caesarean ☐ Forceps ☐ Vacuum extraction

Please list any health problems for the baby after birth: _____

_____

Feeding: ☐ Bottle ☐ Breast fed

Are there any smokers in the household?: YES / NO

Skin Check Have you had a skin check?: YES / NO If YES please state when: ____/____/____

Men's Health Last prostate check (if aged over 40): ____/____/____

Women's Health: When did you last have a:	Date:	Not Sure	Never
Pap Smear	/ /		
BreastCheck	/ /		
Mammogram	/ /		

Number of pregnancies:_____ Number of miscarriages: _____

Lifestyle Health History Do you SMOKE, DRINK, or use other drugs? YES / NO

Do you:	Never	Specify approximate per day/month/year
Drink alcohol?		
Smoke?		

Former smoker, quit date: / / **Current** smoker (number of days/months/years): _____

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

_____

Family History	YES	NO
Have any of your close relatives had heart disease before 60 years of age? (Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery)		
Have any of your close relatives had diabetes?(Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes)		
Do you have any close relatives who had melanoma?		
Have any of your close relatives had bowel cancer before 55 years of age?		
Do you have more than one relative on the same side of the family who had bowel cancer at any age? (Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces,nephews and grandchildren)		
Have any of your close male relatives had prostate cancer before 60 years of age?		
Have any of your close female relatives had ovarian cancer?		
Have any of your close relatives had breast cancer before 50 years of age?		
Do you have more than one relative on the same side of your family who has had breast cancer at any age? (Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren)*		
Is there a history of mood disorder in your immediate family? Depression anxiety ptsd		
Family h/o of schizophrenia or psychosis		
Family h/o of Pulmonary embolism/clots or Deep vein thrombosis		
If there is a family history of cancer, please specify what kind:		
Do you have any family history of Bleeding disorder (Eg vonvillebrands)		

Would you like to nominate some one to discuss or release of medical information? YES / NO

Patient Information

I hereby give permission for the following to be released to:

Name: _____ Relationship to you: _____

Results : YES / NO

Medical Information: YES / NO

Appointment Details: YES / NO

Messages: YES / NO

Patient Name (Please Print): _____ Date of birth: ____/____/____

Signature: _____ Date: ____/____/____

Would you like your previous medical records sent to this practice? YES / NO

If you have medical records at another practice, and wish to now use this practice as your preferred health care provider, please ask our Reception Staff to arrange for your records to be transferred. Our Reception Staff will ask you to complete and sign a Medical Records Request Authority.

Health Information Collection and Use Consent Form

Please read this consent form carefully prior to signing. 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.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information.

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 and disclosed and record your consent or restrictions to this consent.

We require your consent to collect personal information about you and to use the information you provide in the following ways: · Administrative purposes in running our medical practice. · Billing purposes, including compliance with Medicare and Health Insurance Commission requirements. · Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral 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, locums etc. attached to 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. Usually information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to "opt out" of any involvement. · To comply with any legislative or regulatory requirements e.g.,notifiable diseases.

· For legal related disclosure as required by the court of law · For reminder letters which may be sent to you regarding your health care and management. Please read this consent form carefully, and sign where indicated below. 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.

Consent to receive SMS appointment reminders from the clinic: YES / NO

Consent to receive emails from the clinic: YES / NO

I am aware of my right to access the information collected about me, except in circumstances where access might be withheld. I understand I will be given an explanation in these circumstances. I have been advised of the estimated costs in respect of the proposed medical services. I accept responsibility for payment of this account, including if any nominated insurer does not pay the anticipated costs or declines liability of any injury or claims.

Full Privacy policy available on website - www.narangbastationmedical.com.au/nsmc-practice-terms-of-use/

Patient's name: _____ Date: ____/____/____

Patient's signature (signed as guardian for child): _____