North Geelong Medical Clinic

# Patient Registration Form

**Title:** Mr / Mrs / Miss / Ms / Mast / Other_____

**First Name:** _____ **Middle Name:** _____ **Surname**: _____

**Preferred Name**: _____ **DOB:** _____

**Birth Sex:** Female Male Other

**Gender Identity:** _____ **Pronouns:** _____

**Country of Birth/ Ethnicity :**_____

**To assist with health initiatives, are you Aboriginal or Torres Strait Islander?**

□ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander □ No

---

**Address**

Street Address: _____

Suburb: _____ Postcode: _____

**Postal Address** (if different from above)

P O Box/Street: _____

Suburb: _____ Postcode: _____

**Mobile No**. _____**Home Ph. No**. _____**Work Ph. No**. _____

**Email Address**: _____

---

**Next of Kin:** Name: _____

Phone No: _____ Relationship: _____

**Emergency Contact:** Name: _____

Phone No: _____ Relationship: _____

---

**Private Health Fund:** _____

**Membership No:** _____

---

**SMS/Email Consent**

**Do you authorise the practice to send you SMS/email appointment confirmations via Hot Doc/Best Practice?**

□ Yes □ No

**Do you authorise the practice to send you SMS messages regarding results or recalls via Hot Doc/Best Practice?**

□ Yes □ No

**Our practice provides our patients with preventative care and early case detection reminders (e.g., immunisations, annual health checks, skin checks, cervical screening). Do you wish to have any relevant reminders sent to you?**

□ Yes – via SMS or □ Yes – via mail □ No

**Signature:** _____

---

**Please return completed form to reception with your Medicare card and current pension card if applicable. North Geelong Medical Clinic is a private billing practice, payment is expected and appreciated on the day of consult.**

North Geelong Medical Clinic

## 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 collected may be collected by a number of different methods and examples may include: medical test results, notes form 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 my 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.

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____

Office use – scan into patient file -BP comms Consent – Link to signed consent

North Geelong Medical Clinic

# Medical Information

**Do you have any allergies or are you sensitive to any medications?**

□ Yes □ No

If yes, please list:

_____

_____

_____

**Do you have or had a history of the following?** (please include details and date of diagnosis if known)

**Operations:** □ Yes □ No _____

**Asthma:** □ Yes □ No _____

**Diabetes:** □ Yes □ No _____

**Hypertension:** □ Yes □ No _____

**Chronic Illness:** □ Yes □ No _____

**Other:** □ Yes □ No _____

_____

**Do you smoke?** □ Yes □ Never smoked □ Ex-smoker

If currently smoking: How many per day: _____ If Ex-smoker: Year Quit: _____

**Do you drink Alcohol?** □ Yes □ No

If Yes: how many per day: _____ How many days per week: _____

---

**Preventative Health Screening**

**Have you had a bowel screening test?** □ Yes □ No

If yes, date last performed: _____

**Have you had a mammogram?** □ Yes □ No

If yes, date last performed: _____

**Have you had a cervical screening test (e.g., pap smear?)** □ Yes □ No

If yes, date last performed: _____