Lindisfarne Medical Group

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 patients are asked to complete the following.

Patient Information Detail

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other_____

First Name: _____ Middle name:_____ Known as:_____

Family Name:_____ Date of Birth: _____

Medicare No: _____ Ref: _____

To assist with health initiatives are you:- ☐ Neither Aboriginal or Torres Strait Islander

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal or Torres Strait Islander

Pension / HCC: _____ Exp: ____/ _____

DVA: _____ ☐ Gold card ☐ White card Exp: ____/ _____

Address: _____

Suburb: _____ Postcode: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Email: _____

Occupation: _____

Country of Birth: _____

Is English your first language? ☐ Yes ☐ No

- If no, please indicate if an interpreter is required. ☐ Yes ☐ No

Please indicate language: _____

Private Health Insurance: ☐ Yes ☐ No Fund name: _____ Member Number _____

Would you like to be contacted via SMS for appointment reminders or messages? ☐ Yes ☐ No
Can we leave messages for you identifying the surgery as the caller? ☐ Yes ☐ No

Next of Kin: In the event of an emergency please provide details of who we should contact:-

Full Name: _____Relationship: _____

Contact number : _____

Patient registration & Information Form

Payment is expected on day of consultation. Eftpos facilities are available.

For information regarding billing arrangements for associated services from allied health practitioners such as pathology and radiology, these details should be sought directly from the health provider providing this service.

Please discuss any queries concerning financial arrangements with your Doctor.

Additional Personal Details:

- **Emergency contact** (if different from Next of Kin)

Name:_____ Relationship:_____

Contact Phone Number: _____

What number can we call you on regarding results, recalls or changes to appointments? _____

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding appreciation between people from different nationalities and backgrounds. Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes – Please elaborate_____

Personal medical history:

Previous Operations:	**Example:** Hip replacement				
Dates:	March 2001				

Do you have any **allergies** or are you **sensitive to any drugs or dressings?** ☐ Yes (please list below) ☐ No

_____

_____

Tobacco: ☐ I have never smoked ☐ Ceased smoking: _____ ☐ Smoker ____ per day/week

Please select from the following items if you have any history of:

☐ Asthma ☐Diabetes ☐ Heart related problems ☐ Headaches ☐Bleeding Disorders ☐ Blood Clots

Females: When did you last have a Pap smear:- Date _____ ☐ Not sure ☐ Never

Are you pregnant ☐ Yes ☐ No or breastfeeding:- ☐ Yes ☐ No

Please list current medications (including over the counter medications, vitamins and minerals) below:

_____

Patient registration & Information Form

Reminder Systems:

- The practice routinely sends **SMS appointment reminders** to patients.

  If you do *NOT* wish to have reminders sent, please advise our reception / nursing staff.

  I authorise the following person to take messages regarding recall, reminder or change of appointment

  Name: _____ Relationship: _____ Ph: _____

  Signature to authorise the above: _____

- Our practice provides our patients with **preventive care and early case detection reminders.**

  e.g.:- immunisations, annual health checks, skin checks and pap smears.
  ***Please note that we do not send "junk mail".*
  If you do *NOT* wish to receive such reminders, please advise our reception / nursing staff.

PRIVACY POLICY

We require your consent to collect personal information about you. Please read this information carefully and sign Where indicated below.

This Medical Practice collects information from you for the purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so we may properly access, diagnose, treat and be pro-active in your health care needs. This means we will 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 health care, including treating doctors and specialists outside the practice. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following referrals.

If the Practice undertakes training of students or research activities, then the following clauses may be adopted:

- Disclosure to other doctors in the Practice, locums and by registrars attached to the practice for the purpose of patient care and teaching,
- Disclosures for research and quality assurance activities to improve individual and community healthcare and practice management. You will be informed when such activities are being conducted and given the opportunity ti refuse any involvement.

Please let us know if you do not want your records accessed for these purposes and we will note your records accordingly.

I have read the above and understand the reasons why my details should be collected. I am also aware that this practice has a Privacy Policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but failure to do so might comprise the quality of health care and treatment given to me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I understand I may be contacted by general mail-outs/specific recalls from the Practice with regards to my continuing health management.

SIGNED _____ DATED _____

PATIENT NAME: (Please print) _____
Parent to sign if Patient under 16 years