

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.

Date			Doctor	
Title				
Surname				
First Name				
Preferred Name				
Date of Birth				
Gender				
Country of Origin				
Street Address			Post Code	
Suburb			State	
Postal Address (If different)				
Home Number			Work Number	
Mobile Number			Current Occupation	
Email Address				
Medicare Card No:				
Medicare Ref No:	Number next to your name_____		Medicare Expiry Date:	
DVA (Vet Affairs) Card Number:			DVA (Vet Affairs) Expiry Date:	
Please Circle	Gold Card White Card Other__ Conditions covered by DVA			
Pension Number:			Pension Expiry Date:	
Health Care Card Number:			Health Care Card Expiry Date:	
Next of Kin: (Name and Phone number)	Name:		Phone Number:	
Relation of next of Kin: (Please circle one)	Mother, Father, Husband, Wife, Brother, Sister, Partner, De facto, Fiancé Other_____			
Emergency Contact (Must be different to next of kin)	Name:		Phone Number:	
Do you require an interpreter service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify _____				
Do you identify as being Aboriginal or Torres Strait Islander? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (please state) _____				

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Bay Medical Group is focused on providing the best care to you. To provide this level of integrated quality care, it is essential that your health care team know as much as possible about your existing (and past) health and lifestyle.

If there are any question you would rather not answer, please leave them blank.

Your Health History - Do you have or have had a history of:		Family History: Have any members of your family had: Please specify who: Eg Mother or Father	
Diabetes		Diabetes	
Asthma		Asthma	
Hypertension		Hypertension	
Chronic illness		Chronic illness	
Breast Cancer		Breast Cancer	
Colon Cancer		Colon Cancer	
Heart Disease		Heart Disease	
Stroke		Stroke	
Mental Illness		Mental Illness	
Other		Other	
Are any of the above current illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify_____		
Have you had any Surgery/Operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify_____		
Is your mother alive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cause of death	Age
Is your father alive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cause of death	Age
Are you an Elite Athlete?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sport_____		
What is your Marital Status?		Who do you live with?	
Accommodation (Please Circle)	Owns Home Relative Rental Home Hostel Nursing Home Other_____		
Do you have any allergies or are you sensitive to drugs or dressings? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify_____			
Reaction_____			
Current Medications (including over the counter medications, vitamins and minerals) _____			
What Social/Exercise Activities do you engage in?			
Do you currently drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many days per week 1 2 3 4 5 6 7	How many each day 1 1-3 4-6 7+
Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No		Non Smoker Ex Smoker- Ceased Smoking date _____ Smoker- How many per day_____ Year Started_____	

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Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders, e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

☐ Yes ☐ No

Immunisations - Have you had the following immunisations?

Immunisations:

Tetanus booster	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Hepatitis B	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Hepatitis A	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Influenza	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Pneumococcal	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Polio	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one
Other	date _____	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Haven't had one

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

☐ Yes ☐ No ☐ Unsure

For those 65 years and older: When was the last time you were immunised?

Influenza Date _____ ☐ Not sure ☐ Never
Pneumococcal pneumonia Date _____ ☐ Not sure ☐ Never

Females: When did you last have?

Pap smear Date _____ ☐ Not sure ☐ Never
Breast check Date _____ ☐ Not sure ☐ Never
Skin check Date _____ ☐ Not sure ☐ Never

Males: When did you last have?

An overall check up Date _____ ☐ Not sure ☐ Never
Skin check Date _____ ☐ Not sure ☐ Never

Do you have any health concerns you would like to receive more information on?

SMS CONSENT

Would you like to be contacted via SMS (mobile text message) for: appointments, reminders, recalls and other test reminders or medical services we offer? ☐ Yes ☐ No

SMS is not a secure format of communication and may contain confidential information that is intended for the named recipient. E.g. your name, date & time of appointment and GP Name.

I am the primary user of the mobile phone number _____ and I accept the risk explained above and consent to SMS reminders from Bay Medical Group.

Patient Signature: _____ Date _____

Guardian Name: _____ Signature: _____

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the National 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 from 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). Please review our full [Patient Privacy Policy](#) on our website or ask for a copy at our reception desk.

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): _____