RIVERINA FAMILY MEDICINE

# Patient Registration & Information 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.**

*Please assist us by completing the following:*

**Mr / Miss / Ms / Mrs** **Family Name:** _____

*(Please circle)* **Given Names:** _____

**Date of birth:** __ __ / __ __ / __ __ __ __

**Gender:** **Male** ☐ **Female** ☐ **Other** ☐ _____

**Do you identify as:** ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Non-indigenous Australian**

**Other:** *please specify country of birth*_____

**Address:** _____

**Suburb:** _____ **State:** _____ **Post Code:** _____

**Phone:** **Mobile:**_____ **Home Ph:** _____ **Work Ph:**_____

**Email:** _____

**Would you like SMS results and appointment reminders?** **Yes** ☐ **No** ☐

**My preferred method of contact is** **Mobile Phone** ☐ **Home Phone** ☐

**Do you consent to receiving emails?** **Yes** ☐ **No** ☐

**Do you require the services of a translator?** **No / Yes pls specify**

_____

**Medicare:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ **Ref no.:** __ **Expiry Date:** __ __ / __ __ __ __

**Pension / Health Concession Card:** __ __ __ __ __ __ __ __ __ __ __ __ **Expiry Date:** __ __ /__ __ / __ __ __

**Commonwealth Seniors Health:** __ __ __ __ __ __ __ __ __ __ __ __ **Expiry Date:** _ __ /_ __ / __ __ __ __

**DVA:** **Gold** ☐ **White** ☐ *(Please specify eligibility)* _____**No.** _____

**Private health insurance:** _____ **Membership number:**_____

**Occupation:** _____

**Emergency Contact / Next of Kin**

**Name**: _____

**Address:** _____

**Suburb:** _____ **Post Code:** _____

**Phone:** _____

**Relationship:** _____

**Next of Kin / Parent / Guardian (if under 16)**

**Name:** _____

**Address:** _____

**Suburb:** _____ **Post Code:** _____

**Phone:** _____

**Relationship:** _____

**Date of Birth parent / guardian (if under 16) __ __ / __ __ / __ __ __ __** Ref # Medicare card_____

**Please turn page over to complete consent form.**

# Health Information Collection and Use Consent Form

As a patient of Riverina Family Medicine we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

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.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

*Please read this consent form carefully, and sign where indicated below.*

I confirm that the information I have given is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurses, and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.

- 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.
- 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 reminder letters which may be sent to you regarding your health care and management.

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.

✓ I have read the information above and understand the reasons why my information must be collected.

✓ I understand that I am not obliged to provide any information requested of me but failure to do so may compromise that quality of health care and treatment given to me.

✓ I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

✓ I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

✓ I consent to the handling of my information by the practice for the purpose set out above subject to any limitations on access or disclosure of which I notify this practice.

- **I also agree to pay all accounts on the day of consultation, and**
- **I understand that a fee of $40 may be charged for non-attendance of booked appointments.**

**Patients Name: _____**

**Signature**: _____ (parent or guardian If patient under 16 signed)

## To be completed and handed to your doctor

**Todays date: __ __ / __ __ / __ __ __ __**

**Patients Name: _____D.O.B:_____**

**Allergies:**

Do you have any allergies? Yes ☐ No ☐

If Yes, please list your allergies (including medications) and the reaction:

| Allergic to: | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Smoking history:**

Current smoker: Yes ☐ No ☐

| | |
|---|---|
| If yes, what year did you start: | |
| If yes, how many per day: | |
| If you were a smoker and have stopped, what year did you stop? | |

Are you a: Light smoker ☐ Moderate smoker ☐ Heavy smoker ☐

**Alcohol History:**

Do you drink alcohol (If less than 1 day a week, mark No): Yes ☐ No ☐

| | |
|---|---|
| If yes, how many per days per week: | |
| How many drinks per day would you average? | |