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NEW PATIENT REGISTRATION FORM

PLEASE NOTE: *MyDoc does **NOT** prescribe any Schedule 8 drugs **eg.Endone, Oxycodone, Morphine, Codeine***

Contact Information

Title: **First Name:** **Middle Name:**

Surname:

Date of Birth:

Birth Sex: ☐Female ☐Male **Pronouns:** ☐She ☐He ☐They

Gender: ☐Female ☐Male ☐Non-Binary ☐Transgender ☐Gender Diverse

Ethnicity: ☐Australian Non-Indigenous ☐TSI ☐Aboriginal Other_____

Street Address:

Suburb: **Postcode:**

Postal Address:
(if different to above)

Home Phone: **Work Phone:**

Mobile Phone: **Email:**

Healthcare Identifiers

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

IRN (Number you are on the card**):** **Expiry:** ___/_____

Concession cards: (Please tick appropriate)
☐Health Care Card ☐Pensioner Card ☐Seniors Card ☐DVA (White/Gold/Orange)

Concession card number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Concession card expiry date: _____ /_____ /_____

Next of Kin

Name: Relationship to you:

Address:

Phone Contact:

Mobile Phone:

Emergency Contact Details

Name: Relationship to you:

Address:

Phone Contact:

Social

Marital Status: ☐Single ☐Married ☐Defacto ☐Divorced ☐Widowed

Lives with: ☐Spouse ☐Partner ☐Relative ☐Friend ☐Alone

Occupation: **☐Retired**

Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?
☐ No
☐ Yes – provide details:

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CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

List medications: e.g., Name: **Panamax** Strength: **500mg** Quantity per day: **2 tab three times a day**

Name	Strength	Quantity per day

LIFESTYLE RISK FACTOR INFORMATION
Smoking
☐ Non smoker
☐ Ex smoker Ceased - date_____
☐ Smoker how many ____ /day Which year started_____
Alcohol
☐ Non Drinker
☐ Yes - how many days per week ____ standard drinks per day_____

HEIGHT **cm**

WEIGHT **kg**

Family Health History Information

Have either your mother or father have:
☐ Diabetes
☐ Hypertension (high blood pressure)
☐ Heart Disease
☐ Stroke
☐ Cancer – type (bowel/breast)
☐ Mental Illness (Depression)
☐ Other significant - provide details:

In order to provide you with the highest quality of care, we require the following information from you. This form complies with the RACGP Standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly when required

Patient Consent

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

Your personal 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 information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

I understand that all accounts must be paid at the time of the consultation.

I acknowledge that MyDoc charges a fee for non-attendance and late cancellations of less than 4 hours' notice.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian) _____