Conder Surgery

Patient Registration form (Child)

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.

Appointment Details:
Date: ……

ALL patients are asked to complete the following.

Time: ……

Family Name: …… Middle Name(s)……

Given Name: …… Occupation: ……

Title: □ Mr □ Mrs □ Ms □ Miss □ Dr □ Other …… Date of Birth: ……

Address: ……

…… Postcode: ……

Mobile Phone: …… Home Phone: ……

Email: ……

Emergency Contact: ***In the event of an emergency please provide the details of who we should contact***

Name: …… Contact No: ……

Relationship to you: ……

Next of Kin: ***Complete if different from your emergency contact***

Name: …… Contact No: ……

Relationship to you: ……

Healthcare Identifiers

Medicare No: …… Ref: …… Exp: ___ / _____

Pension/HCC: …… Ref: …… Exp: ___ / _____

Cultural Identity

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

□ Aboriginal □ Torres Strait Islander □ Both Aboriginal & Torres Strait Islander

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures – do you identify as someone from a culturally and /or linguistic diverse background?

No: □

Yes: □ – if so please elaborate _____

Do you require an interpreter service? No: □ Yes: □ Language required _____

Allergy Information

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

……

……

Practice Internal Use: Chart No:…… Dr: …… Staff/PN: ……

Current medications (including over the counter medications, vitamins and minerals):

……

……

……

……

Family history

Have any of your family been diagnosed with or suffered from:

□ Diabetes □ Respiratory disease

□ Asthma □ Cancer

□ Cardiovascular disease □ Other significant – provide details

□ Chronic Kidney disease

If yes, please elaborate……

……

Your health history

Height: ……cms Weight: ……..kgs Waist measurement: ……cms

Your Medical History:

- Do you have or have had a history of:

□ Asthma □ Hypertension □ Chronic Illness □ Diabetes □ Other

If other, please elaborate: ……

Operation history (if applicable):

Details: …….. Date: ……

Details: …….. Date: ……

Details: …….. Date: ……

<u>Immunisations</u>:

An up to date record of your current immunisation status is valuable medical information. This would include:

Tetanus	Hepatitis A (1&2)	Hepatitis B (1&2)
Flu	Pneumococcal	Polio
Gardasil (1,2&3)	Measles	Any other relevant immunisation

Please check If you have any relevant information pertaining to your immunisation history and update our practice nurse/Doctor so it can be noted correctly in your medical records.

Practice Internal Use: Chart No:…… Dr: …… Staff/PN: ……

Other: If you think there is any other relevant information that will affect or have influence over your treatment/ advise we provide you with, please note below.

……

……

……

……

……

Are you an Interstate or Overseas visitor to Canberra? □ Yes □ No

Do you intend to use practice for ongoing medical care? □ Yes □ No

Reminder System:

Our practice regularly sends out reminders for preventative care and early detection reminders. (e.g.: immunisations, annual health checks, skin checks, pap smears). If you do not wish to receive these reminders, please advise our staff.

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 healthcare. To enable ongoing care, 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 information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be 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, ant that it may be used and 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/Email/Phone
- Disclosure to others involved in your health care, including treating doctors and specialist 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.

Practice Internal Use: Chart No:…… Dr: …… Staff/PN: ……

- 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.
- Uploading of EHealth summaries/event summaries, results, medications & specialist correspondence to your, my health record.
- Where you have signed a release of information form for 3rd party disclosure (e.g such as insurance, superannuation, workers compensation claims or transfer of medical records forms).

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.

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 understood 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 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, contact via phone, or via email. 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, the patient signing – your name (please print) _____

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

Thank you for providing this information that will allow us to provide you with the highest standard of medical care.

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____

Staff Name: (please print) _____

Practice Internal Use: Chart No:…… Dr: …… Staff/PN: ……