PRIMO MEDICAL CLINIC

## Patient Registration Form

**Title** (please circle) Dr/ Mr/ Mrs/ Ms/ Miss/ Mstr/ Rev/ Sr/ Other____
**First Name***: _____ **Surname***: _____
**Preferred Name**: _____ **Date of Birth***: _____

**Sex:**
☐Male ☐ Female

**Preferred Pronouns:**
☐ She/her/hers
☐ He/him/his
☐ They/them/theirs

**Gender Identity:**
☐ Male
☐ Female
☐ Non-Binary
☐ Transgender

**Address***: _____
**Suburb***: _____ **Postcode**: _____
**Postal Address** As Above? Yes / No
**P O Box/Street:** _____
**Suburb**: _____ **Postcode**: _____

**Mobile No**: _____ **Home Ph. No**. _____
**Work Ph. No**. _____
**Email Address**: _____

**Do you authorise the practice to send you SMS appointment confirmations?** (circle) **YES / NO**

**If we need to contact you, what is your preferred method of contact?**
□ **Home Phone** □ **Mobile Phone** □ **Email** □ **Mail**

**Medicare Number*:**_____ **Exp:** ___/___ **Line Number:**___
**Pension/Health Care Card*** (circle) **:**_____**Exp:** ___/___/___
**DVA Card Number*:** _____ **Exp:** ___/___/___

**Next of Kin/Emergency Contact***
**First Name**: _____ **Surname**: _____
**Phone No:** _____ **Relationship**: _____

**Biostatistics/Demographics:**

**Ethnicity:** _____

**Are you Aboriginal or Torres Strait Islander?**

□Aboriginal □Torres Strait Islander □Aboriginal & Torres Strait Islander □No

**Occupation :** _____

**Religion :** _____

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

_____

**Do you have any allergies or are you sensitive to any drugs or dressings:**

_____

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**Do you have any previous illness or medical condition we need to be aware of (tick below)?**

| | | |
|---|---|---|
| □ High blood pressure | □ Angina | □ Diabetes |
| □ Bleeding tendency | □ Stomach Ulcer | □ Asthma |
| □ Hepatitis | □ Skin cancer surgery | □ Varicose Veins |
| □ Deep vein thrombosis | □ Currently pregnant | □ HIV |
| □ Heart valve surgery | □ Other – provide relevant details below | |

_____

_____

**Your Health Information**

To enable ongoing care and total quality improvement within this practice 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 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 form 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).

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;
- 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): _____