Patient Registration Form

Welcome to Carlingford Medical Clinic. We are committed to providing our patients with quality care. To do this it is essential that your health record is kept up to date and accurate.

CARLINGFORD MEDICAL CLINIC

YOUR PERSONAL DETAILS

First name: | Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:

Middle name: | Preferred name:

Last name: | Date of birth: __ __ / __ __ / __ __ __ __

YOUR RESIDENTIAL ADDRESS

Street no.& name: | City/Suburb: | Postcode:

YOUR POSTAL ADDRESS *(IF DIFFERENT FROM RESIDENTIAL ADDRESS)*

Street no.& name: | City/Suburb: | Postcode:

YOUR PHONE NUMBER(S)

Mobile: | Work: | Home:

Would you like to receive clinical reminders via text messaging? ☐ Yes ☐ No | Preferred contact: ☐ Mobile ☐ Work ☐ Home ☐ Mail

YOUR OCCUPATION

Occupation: ☐ Unemployed ☐ Retired

YOUR RELATION TO HEALTH INITIATIVES - DO YOU IDENTIFY YOURSELF AS ABORIGINAL OR TORRES STRAIT ISLANDER?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

If no, what is your cultural background? _____

YOUR MEDICARE INFORMATION

Medicare No.: __ __ __ __ __ __ __ __ __ __ __ | Line No.: __ | Expiry: __ __ / __ __ __ __

YOUR PENSION INFORMATION *(IF APPLICABLE)*

Pension/HCC No.: | Ref. No.: | Expiry: __ __ / __ __ / __ __ __ __

Card type: ☐ Pension Concession Card ☐ Healthcare Card ☐ Commonwealth Senior Health Card

DVA No.: ☐ Gold ☐ White ☐ Lilac ☐ Orange

YOUR HEALTH HISTORY

Do you consent to Carlingford Medical Clinic GPs accessing your 'My Health Record' for the purpose of ongoing medical care?

☐ Yes ☐ No ☐ I have 'Opted Out' for My Health Record

Do you have allergies or are you sensitive to drugs or dressings? ☐ Yes - Please list below ☐ No

Do you or have you ever had any of the following conditions? ☐ Yes - Please tick below ☐ No

☐ Diabetes	☐ Asthma	☐ Heart Problem	☐ Anxiety
☐ Kidney Disease	☐ Epilepsy	☐ High Blood Pressure	☐ Depression
☐ Colon Cancer	☐ Breast Cancer	☐ Stroke	☐ Other _____

** PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM **

YOUR BLOOD GROUP

Do you know your blood group? ☐ Yes, my blood group is __ __ __ ☐ No

FOR FEMALE PATIENTS

Please provide the date of your last Cervical Screening Test __ __ / __ __ / __ __ __ __

FOR YOUR CHILD *(TO BE COMPLETED IF THIS FORM IS FOR YOUR CHILD)*

Is your child up to date with his / her immunisations? ☐ Yes ☐ No

Please provide a copy of your childs most recent immunisation history.

YOUR RELATION TO TOBACCO

☐ I have never smoked ☐ I smoke ☐ I ceased smoking (please advise date) __ __ / __ __ / __ __ __ __

YOUR RELATION TO ALCOHOL

Do you drink alcohol? ☐ Yes ☐ No ☐ Socially

YOUR NEXT OF KIN *(PLEASE FILL OUT, OTHERWISE WE CONSIDER YOUR EMERGENCY CONTACT AS YOUR NEXT OF KIN)*

Name:	Relation:	Phone:

YOUR EMERGENCY CONTACT *(PLEASE FILL OUT, OTHERWISE WE CONSIDER YOUR NEXT OF KIN YOUR EMERGENCY CONTACT)*

Name:	Relation:	Phone:

YOUR PRIVACY & CONFIDENTIALITY

Carlingford Medical Clinic collects information from you for the primary purpose of providing comprehensive quality medical care.

It is important that you do not withhold information that would influence the medical treatment or advice given.

We are committed to patient privacy and confidentiality and will only release information about you to other health professionals involved in your care or when the law requires us to do so.

Please do not hesitate to discuss any concerns or questions about any issues to the privacy of your personal information with your Doctor.

By becoming a patient of Carlingford Medical Clinic and signing this Patient Registration Form, I agree and consent to the following:

I consent to the use of my personal health information by the Carlingford Medical Clinic and other health care providers involved in my medical treatment and health care within this centre.

I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls as necessary.

YOUR SIGNATURE _____ **DATE** __ __ / __ __ / __ __ __ __

REFERRAL SOURCE - How did you hear about this medical practice?

☐ Word of mouth ☐ Telephone book ☐ Drive / walk past ☐ Leaflet / Flyer ☐ Website ☐ Google

OFFICE USE ONLY

(Admin) 1. PATIENT ID HAS BEEN SIGHTED (i.e Medicare or D/L) ☐ **INITIALS:** _____ _____ **DATE:** _____/_____/_____

(Admin) 2. ALL ADMINISTRATIVE INFORMATION HAS BEEN ENTERED ☐ **INITIALS:** _____ _____ **DATE:** _____/_____/_____

(Nurse) 3. ALL CLINICAL INFORMATION HAS BEEN ENTERED ☐ **INITIALS:** _____ _____ **DATE:** _____/_____/_____

(Admin) 4. FORM HAS BEEN SCANNED TO PATIENTS FILE ☐ **INITIALS:** _____ _____ **DATE:** _____/_____/_____