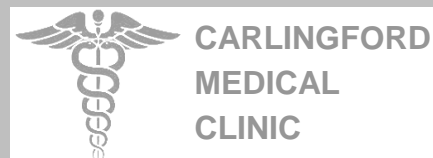


Patient Registration Form

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.



YOUR PERSONAL DETAILS

First name:	Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other:
Middle name:	Preferred name:
Last name:	Date of birth: ____ / ____ / ____

YOUR RESIDENTIAL ADDRESS

Street no. & name:	City/Suburb:	Postcode:
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YOUR POSTAL ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)

Street no. & name:	City/Suburb:	Postcode:
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YOUR PHONE NUMBER(S)

Mobile:	Work:	Home:
Would you like to receive clinical reminders via text messaging? <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred contact: <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Mail

YOUR OCCUPATION

Occupation:	<input type="checkbox"/> Unemployed <input type="checkbox"/> Retired
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YOUR RELATION TO HEALTH INITIATIVES - DO YOU IDENTIFY YOURSELF AS ABORIGINAL OR TORRES STRAIT ISLANDER?

<input type="checkbox"/> No	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> Aboriginal and Torres Strait Islander
If no, what is your cultural background? _____			

YOUR MEDICARE INFORMATION

Medicare No.: _____	Line No.: ____	Expiry: ____ / ____
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YOUR PENSION INFORMATION (IF APPLICABLE)

Pension/HCC No.:	Ref. No.:	Expiry: ____ / ____ / ____
Card type: <input type="checkbox"/> Pension Concession Card <input type="checkbox"/> Healthcare Card <input type="checkbox"/> Commonwealth Senior Health Card		
DVA No.:	<input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Lilac <input type="checkbox"/> Orange	

YOUR HEALTH HISTORY

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I have 'Opted Out' for My Health Record
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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

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> 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 child's 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: ____/____/____