Patient RegistrationForm

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 個人信息

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

Middle name: | Preferred name:

Last name: 姓: | Date of birth: 出生日期: ___ ___ / ___ ___ / ___ ___ ___ ___

Gender ID: ☐ Male ☐ Female ☐ Non-Binary ☐ Trans ☐ Gender Diverse | Birth Sex: ☐ Female ☐ Male ☐ Other

YOUR RESIDENTIAL ADDRESS 家庭住址

Street / no.: 街道名與號碼: | City/Suburb: 區: | 郵政編碼

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

Street name & no.: | City/Suburb: | P/code:

YOUR CONTACT DETAILS

Mobile: 手 機: | Work: 工作 號碼: | Home: 住宅號碼:

Email: 邮箱

Would you like to receive clinical reminders via text messaging? 您是否願意接收診所的短信提醒? ☐ Y ☐ N | Preferred contact: ☐ Mail ☐ Email

YOUR OCCUPATION 職業

Occupation: | ☐ Unemployed 無業 ☐ Retired 退休

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? 您來自哪個國家?

YOUR MEDICARE INFORMATION 您的醫療保健卡

Medicare No.: 號碼: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ | Line No.: 排行: | Expiry: 有效期: ___ ___ / ___ ___ / ___ ___ ___ ___

YOUR PENSION INFORMATION ***(IF APPLICABLE)***

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

Card type:

DVA No.:

YOUR NEXT OF KIN: 您的親屬

Name: 名字 | Relation: 關係 | Phone: 聯絡電話

YOUR EMERGENCY CONTACT ☐ ***please tick box if same as Next of Kin***

Name: 名字 | Relation: 關係 | Phone: 聯絡電話

YOUR PRIVACY & CONFIDENTIALITY 您的隱私和保密

Carlingford Medical Clinic 收集您的資訊的主要目的是提供全面且優質的醫療服務。重要的是，請您不要隱瞞會影響醫療治療或所提供建議的資訊。我們致力於保護患者隱私和保密，並且只會向參與您護理的其他健康專業人員或在法律要求時披露您的資訊。如果您對個人資訊隱私問題有任何疑慮或疑問，請隨時與您的醫生討論。成為 Carlingford Medical Clinic 的患者並簽署本患者登記表，即表示我同意並同意以下內容：

我同意 Carlingford Medical Clinic 和本中心參與我的醫療和保健的其他醫療保健提供者使用我的個人健康資訊。我同意透過上述做法向直接或間接參與我的個人醫療保健或醫療的其他醫療保健提供者披露我的個人健康資訊。作為這種做法提供的預防性健康服務的一部分，有需要我們會在例行檢查到期時發出提醒和召回。

YOUR SIGNATURE 您的簽名 | ***DATE 日期***

** 請翻面並完成表格 /PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM **

YOUR HEALTH HISTORY 您的健康史

您是否同意您的健康相關信息上傳至政府公共醫療系統?

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

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

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

您是否有任何過敏症或藥物或傷口包紮材料過敏? 有- 請詳列

您是否患有或曾患過以下任何一種疾病? 是的- 請勾選

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

☐ Diabetes 糖尿病 Type1 ☐ Type 2 ☐ ☐ Asthma 哮喘 ☐ Heart Problem 心臟問題 ☐ Anxiety 焦慮症

☐ Kidney Disease 腎臟疾病 ☐ Epilepsy 癲癇 ☐ High Blood Pressure 高血壓 ☐ Depression 抑鬱症

☐ Colon Cancer 腸癌 ☐ Breast Cancer 乳腺癌 ☐ Stroke 中風 ☐ Other 其他 _____

YOUR BLOOD GROUP 您的血型 您知道您的血型嗎?

Do you know your blood group? ☐ Yes, my blood group is ___ ___ ___ 是的，我的血型是 ☐ No 我不知道

FOR YOUR CHILD *(TO BE COMPLETED IF THIS FORM IS FOR YOUR CHILD)* 對於您的子女(如果這是為了您的子女，請填寫)

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

您的子女是否已接種最新疫苗

Please provide a copy of your child's most recent immunization history / 請提供您子女最近接種的疫苗紀錄

YOUR RELATION TO TOBACCO 吸煙紀錄

從不 我吸煙 我戒煙了 (戒煙時間)

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

YOUR RELATION TO ALCOHOL 飲酒紀錄

您喝酒嗎? 是 否 偶爾

Do you drink alcohol? ☐ Yes ☐ No ☐ Socially

FOR FEMALE PATIENTS 僅限女性病人回答 請提供妳上一次宮頸篩查測試的日期?

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

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

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

OFFICE USE ONLY

Admin 1. PATIENT ID HAS BEEN SIGHTED (i.e. Medicare card or D/L) ☐ INTIALS: __ __ DATE: ____ / ___ / ___

Admin 2. ALL ADMINISTRATIVE INFORMATION HAS BEEN ENTERED ☐ INTIALS: __ __ DATE: ____ / ___ / ___

Nurse 3. ALL CLINICAL INFORAMTION HAS BEEN ENTERED ☐ INTIALS: __ __ DATE: ____ / ___ / ___

Admin 4. FORM HAS BEEN SCANNED TO PATIENT FILE ☐ INTIALS: __ __ DATE: ____ / ___ / ___