PATIENT REGISTRATION

Rochedale Family Practice

The information you provide is treated confidentially and will enable the doctor(s) to assess your health needs.

(Please circle one) Mr Mrs Miss Ms Master Dr Prof

First Name: _____ Surname: _____

Preferred Name: _____ Date of Birth: _____ /_____ /_____

Gender: Male / Female / Other

Marital Status: Single / Married / De facto / Other: _____

Address: _____ Suburb:_____ Postcode: _____

Phone: (H) _____ (W) _____ (Mob) _____

Email: _____

Occupation: _____

Next of Kin First and Last Name: _____

Relationship: _____ Ph/Mob: _____

Emergency contact First and Last Name: _____

Relationship: _____ Ph/Mob: _____

Health Initiatives Country of Birth: _____

Do you identify yourself as Aboriginal or Torres Strait Islander? Yes/No

If yes, please select what you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal/Torres Strait Islander

Medical Information

Medicare Card Number: _____ Ref No (IRN): ____ Card Expiry: ___ / 20_____

DVA Card (if applicable) Number: _____ Type: Gold/White Card Expiry: ___ / 20_____

Pensioner / Health Care Card / Seniors Concession Card (if applicable):

Card Number: _____Card Expiry: ___ /__ / 20____ Type:_____

Your Health History

Do you have any Allergies or are you sensitive to drugs or dressings? Yes/No

If yes, please specify: _____

Do you SMOKE? ☐ Never

☐ Ex-smoker Quantity/day: _____ Year started: _____ Year stopped: _____

☐ Smoker Quantity/day: _____ Year started: _____

Do you DRINK ALCOHOL? ☐ Never ☐ Yes Standard drinks/day: _____ Days/week: _____

Do you have or had history of?

Operation: YES/NO If yes: please provide details: _____ Date of operation: _____

Asthma: YES/NO If yes, please include date of diagnosis: _____

Diabetes: YES/NO If yes, please include date of diagnosis: _____

Hypertension: YES/NO If yes, please include date of diagnosis: _____

Chronic Illness/Other: YES/NO

If yes, please include details of diagnosis: _____Date of diagnosis: _____

Please list any Medications that you are using regularly or occasionally: _____

Communication

Do you consent to be contacted by the practice via SMS/Text for: Routine Reminders/Recalls: YES/NO

Rochedale Family Practice

Health Information Collection, Use and Disclosure Consent Form

Rochedale Family Practice 2/48-54 Koobil St Rochedale Q 4123

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes including billing, compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to my Health Summary being uploaded for my PCEHR	☐

Patient's Full Name : …….

Patient's Signature : ……. **Date :** …….

Parent/Guardian Signature: …….

Name: (printed) ……. **Date:** …….