YARRAM MEDICAL CENTRE

PATIENT REGISTRATION **ALL INFORMATION IS CONFIDENTIAL**

Surname			
First Names		Preferred Name	
Date of Birth		Birth sex	Gender Identity
Title (please circle)	Mr Mrs Ms Miss Mast	she/her/hers he/him/his they/them/theirs	
Street Address		Postal Address	
Suburb & Post Code			
Home Phone		Work Phone	
Mobile Phone			
Email			
Country of Birth			

Are you Aboriginal or Torres Strait Islander? (Please Circle) Yes / No

Cultural background:

Preferred language:

Medicare Number	____/_____/_____/____ ___/____/____/____/___ / ____ Pt number _____ Expiry Date _____/_____
Pension Number	Expiry Date
Health Care Card Number & Type	Expiry Date
DVA Gold / White	Expiry Date

Who is responsible for the account?	Self / Parent / Guardian or Carer (please circle)
Parent / Carer / Guardian Name	
Contact Details if different from above	

Do you have private health cover? Y / N Fund: _____

Member No: _____/_____

Do you have Ambulance cover? Y / N

Do you have any allergies or are you sensitive to drugs or dressings: Y / N If yes, please list:

Are you registered for PCEHR? Y / N (Personally controlled electronic health record)

Do you have an Advance Care Plan Y / N

If No, are you interested in discussing this with our practice nurse? Y / N

Emergency Contact Name		**Phone**	
Emergency contact address:			
Relationship to patient::			
Next of kin name		**Phone**	
Relationship to patient:			

CONFIDENTIAL PATIENT INFORMATION	
DATE	
PATIENT NAME	DATE OF BIRTH

Your Health History – do you have or have you had a history of?

☐ Operations

☐ Recent investigations

☐ Asthma

☐ Diabetes Type I ☐ Type II ☐

☐ Hypertension

☐ Chronic Illness

☐ Mental Illness (if yes, do you have any services in place?)

☐ Disabilities

☐ Other

Family history – have any members of your family had:

☐ Diabetes Type I ☐ Type II ☐

☐ Asthma

☐ Heart Disease

☐ Cancer

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

CONFIDENTIAL PATIENT INFORMATION	
DATE	
PATIENT NAME	DATE OF BIRTH

Immunisations – have you had the following immunizations?

Tetanus booster	Date _____	☐ Don't Know	☐ Haven't had one
Hepatitis B	Date _____	☐ Don't Know	☐ Haven't had one
Hepatitis A	Date _____	☐ Don't Know	☐ Haven't had one
Influenza	Date _____	☐ Don't Know	☐ Haven't had one
Pneumococcal	Date _____	☐ Don't Know	☐ Haven't had one
Polio	Date _____	☐ Don't Know	☐ Haven't had one
Whooping Cough	Date _____	☐ Don't Know	☐ Haven't had one

For those 65 years and older: when was the last time you were immunised?

Influenza	Date _____	☐ not sure	☐ never
Pneumococcal	Date _____	☐ not sure	☐ never

Children's immunisations – if completing this form for a child are their immunisations up to date?

☐ Yes ☐ No

Sun protection: How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

Females: When did you last have?

Pap smear	Date _____	☐ not sure	☐ never
Breast Check	Date _____	☐ not sure	☐ never

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never
PSA	Date _____	☐ not sure	☐ never

CONFIDENTIAL PATIENT INFORMATION	
DATE	
PATIENT NAME	DATE OF BIRTH

Do you have special dietary requirements? Eg vegan/vegetarian?			
Have you had a lung function test	Yes / No	Approx Date	
Have you ever had an ECG	Yes / No	Approx Date	
Have you had a cholesterol check	Yes / No	Approx Date	
Have you had your hearing tested	Yes / No	Approx Date	
Do you wear a hearing aid	Yes / No		
Have you had your eyes checked	Yes / No	Approx Date	
Do you see a dentist	Yes / No	Approx Date	
Do you wear dentures	Yes / No		
Do you exercise	Yes / No	Type	

Do you drive	Yes / No
Do you sleep well	Yes / No
Do you snore	Yes / No
Do you have sleep apnoea	Yes / No
Do you see an alternative health therapist	Yes / No
Do you currently have any Allied Health Service	Yes / No (if yes, please list below)

Social History

- □ Tobacco: _____ day / week or Ceased Smoking – date _____
- □ Alcohol: _____ day / week / month (circle the one applicable)
- □ Drug use: _____ (type and frequency)

Do you have any carer responsibilities? **Yes / No** If yes list details:

_____

_____

Height		Full ward urine test	
Weight		BP	
BMI		BSL	

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OFFICE USE ONLY

Data Entered by: Staff Name: _____ Date_____

APP Patient Consent Form – Yarram Medical Centre

Welcome to Yarram Medical Centre.
Please read this consent form carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent. Your personal 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 information is used or disclosed. The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and Practice Management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirement e.g. notifiable diseases.
- 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.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give my permission for my personal information to be collected, used and disclosed as described above. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
Patient Name: (Please Print) _____

Signature: _____Date:_____

If not Patient signing - Your name (Please Print)_____

Your relationship to patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (Staff Signature)_____