One HealthCare
ADDING CARE TO HEALTH
WOODSIDE

PO Box 315
23 Nairne Road
WOODSIDE SA 5244
Ph: 8389 7232 Fax: 8389 9032
ABN 30 611 458 381
Email: contact@1healthcare.com.au

PATIENT REGISTRATION FORM

Title: Mr/Mrs/Ms/Miss/Dr/Other ..... Given Name: .....

Family Name: ..... Preferred Name: .....

Date of Birth: ...../...../..... Gender: Male/Female/Others (please specify) .....

Medicare No..... Ref No..... Expiry Date: ...../...../.....

Concessions: Pension Number: ..... Expiry Date: ...../...../.....

Health Care Card No: ..... Expiry Date: ...../...../.....

Department of Veterans Affairs No..... Gold Card ( ) White Card ( )

Street Address: .....

..... Suburb: ..... Postcode: .....

Postal Address: (if different): .....

Home Phone: ..... Work Phone: ..... Mobile phone: .....

E-mail Address: ..... Occupation: .....

Country of Birth: ..... If not born in Australia, year of arrival in Australia: .....

Ethnicity: ..... Do you identify as an Aboriginal and/or Torres Strait Islander? .....

Marital Status (please circle): Single / Married / Widowed / Divorced / De-facto / Separated

Next of Kin: ..... Phone: ..... Relationship: .....

Emergency Contact: ..... Phone: ..... Relationship: .....

YOUR HEALTH HISTORY

Do you have any allergies? Medication/Dressing/Food? Please elaborate**.** .....

Do you have history of any of the following?

Operations / Asthma / Diabetes / Hypertension / Other. Please elaborate .....

CURRENT MEDICATIONS, including vitamins, minerals etc.

.....

IMMUNISATION STATUS

Childhood Immunisation Completed: **YES /NO** Whooping cough vaccine: No / Yes / Date: .....

Tetanus Booster: No / Yes / Date: ..... Influenza vaccine: No / Yes / Date: .....

Others: .....

FAMILY HISTORY

Father: Diabetes/Hypertension/Heart disease/Stroke/Colon Cancer/Depression/Others .....

Mother: Diabetes/Hypertension/Heart disease/Stroke/Colon Cancer/Depression/Others .....

SOCIAL HISTORY

Smoking? **YES/NO** No. of cigarettes per day..... Ex-smoker? Ceased smoking date ...../...../.....

Alcohol? **YES/NO** How many days per week? ..... How many drinks per day? .....

How often do you drink more than 6? ..... Drug use? **YES / NO**

FOR FEMALES, when did you last have Pap-smear: ...../...../.....

REMINDER SYSTEMS: Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears. These would be mailed/texted to you. **Please indicate if you do not wish to have relevant health reminders sent to you.** .....

How did you hear about our Surgery? .....

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Health Information Collection and Use Consent Form

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 and treat and be proactive in your health care needs. We aim to protect the privacy and ensure secure storage 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

- ☐ Administrative purposes in running our medical practice
- ☐ Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- ☐ Disclosure to other doctors in the practice, locums and Allied Health Professionals (physiotherapist, podiatrist, clinical psychologist) attached to the practice for the purpose of patient care and teaching, and specialists outside of this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- ☐ For research and quality assurance activities to improve individual and community health 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 legislation or regulatory requirements e.g. notifiable diseases.
- ☐ For reminder letters, which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some or 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 obligated to provide any information requested of me, but failure to do so may compromise the quality of the health care and treatment given to me.
I am aware of my rights to access the information collected about me, expect in 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 understand that depending on the age of my child (16 and over) and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.
I consent to the handling of my information by the practice for the purpose set out above, subject to any Limitations on access or disclosure of which I notify this practice.

If you are unsure about any of the above and would like to discuss this further with someone from the practice, please do so before you sign.

Patient's name: ..... Signature: ..... Date: ...../...../.....

Signed as Guardian for child: ..... Name (printed): .....

FOR OFFICE USE

FORM PROCESSED BY: ..... **SIGN**: ..... **DATE:** .....