Your doctor: Dr. _____

NEW PATIENT REGISTRATION FORM

The doctors who operate from the practice are committed to providing their patients with the best care. To do this it is essential that your medical records are up to date and accurate. Please assist your doctor by completing the following:

SURNAME:		**Mr ☐ Mrs ☐ Ms ☐ Master ☐ Miss ☐**		
First Name:		**Date of Birth:**		
Middle Name(s):				
Gender:	**Male Female Unknown Other**			
Medicare Number:	__ __ __ __ __ __ __ __ __ __	**Patient No:**	**Expiry Date:**	
DVA (Dept of Veteran Affairs):	**Gold / White (Please circle)**	**Card No:**		
Home Address:		**Postal Address:**		
Phone:	**Home:**	**Work:**	**Mobile:**	
Email:				
Occupation:				
Country of Birth:				
Do you identify as Aboriginal or Torres Strait Islander?	**Aboriginal ☐ Torres Strait Islander ☐ Neither ☐**	**Are you registered for Closing the Gap? NCACCH no**		
Pension Number:				
Health Care Card:		**Expiry Date:**		
Private Health Cover:	**Fund:**	**Member no:**		
Emergency Contact:	**Name:** **Phone:** **Relationship:**			
Next of Kin:	**Name:** **Phone:** **Relationship:**			
If a CHILD, please give Parents names	**Mother:** **D.O.B:** **Phone:**	**Father:** **D.O.B:** **Phone:**		

Once you have completed filling in this form, please return it to one of our Reception Staff

PATIENT INFORMATION

The doctors who practice from Lake Kawana are required to collect personal information about you (or your child/dependent). Your personal health information may be disclosed to others involved in your healthcare, such as other doctors and health care providers.

The doctors who practice from Lake Kawana participate in research, professional development, and quality assurance/improvement (QA) activities from time to time, to improve individual and community health care and practice management. At times de-identified information (anonymous) may be collected about you for the purpose of research and clinical audits. At times, your doctor may request the presence of a third party to be present during your consultation. This may include a practice nurse or medical student. Your further consent will be requested prior to any other third party being invited to attend your consultation.

CONSENT

By signing this form, I acknowledge that the doctors who practice from Lake Kawana General Practice will collect and store personal health information about me (and my child/children if applicable). This information may be shared with other health professionals for the sole purpose of enhancing my whole health care needs. I give my consent to be part of the Practice's National and State recall and reminder systems.

By signing this form, I agree to the above and understand that I may withdraw my consent at any time:

Signed: _____ **Dated**:_____
(Patient / Parent / Guardian)

Signed: _____ **Dated**:_____
(Staff Member)

WOULD YOU LIKE YOUR PREVIOUS MEDICAL RECORDS SENT TO YOUR DOCTOR? ☐ Yes ☐ No

If you have medical records at another practice and wish to now use the doctor who provides medical services **to you** from Lake Kawana General Practice as your preferred health care provider, please ask our reception staff to arrange for your records to be transferred. The reception staff will ask you to complete and sign a ***Medical Records Request Authority.***

HEALTH HISTORY FORM

The doctors who operate from the practice are committed to providing their patients with the best care.
To do this it is essential that your medical records are up to date and accurate. Please assist your doctor by completing the following:

SURNAME:		**Mr ☐ Mrs ☐ Ms ☐ Master ☐ Miss ☐**
First Name:		**Date of Birth:**
Middle Name(s):		

Your HEALTH HISTORY - Do you have or have ever had a history of?

☐ Operations ☐ High blood pressure ☐ Asthma ☐ Epilepsy ☐ Diabetes

☐ Any other major health event or illness (please use the space below):

Do you have any ALLERGIES or are you SENSITIVE to DRUGS or DRESSINGS?

☐ Yes (If yes please list below) ☐ No

IMMUNISATIONS - Have you had the following immunisations?

Tetanus booster	date_____	☐ Do not Know	☐ Have not had one.
Hepatitis B or A	date_____	☐ Do not Know	☐ Have not had one.
Influenza	date_____	☐ Do not Know	☐ Have not had one.
Pneumococcal	date_____	☐ Do not Know	☐ Have not had one.
Polio	date_____	☐ Do not Know	☐ Have not had one.

Children's Immunisations - If completing this form for a Child are their immunisations up to date?

☐ Yes ☐ No ☐ Do not Know.

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

Do you SMOKE, DRINK, or use other DRUGS?

☐ Tobacco: _____ day / week Ceased Smoking - date _____

☐ Alcohol: _____ day / week / month (circle the one applicable)
☐ Drug use: _____ (type and how often used?)

FAMILY MEDICAL HISTORY - Have any members of your family had?

☐ Diabetes ☐ Mental illness ☐ Asthma ☐ Heart Disease
☐ Cancer (e.g., Bowel, Prostate, Breast, Melanoma?) ☐ Other? _____

For Females:	**When did you last have?**		
Pap Smear	Date _____	☐ not sure	☐ never
Mammogram	Date _____	☐ not sure	☐ never

For Males:	**When did you last have?**		
An overall check-up	Date _____	☐ not sure	☐ never

Reminder Systems:

The doctors provide their patients with preventative care and early case detection reminders, e.g., immunisations, annual health checks, skin checks and pap smears. We use SMS and Email for appointment reminders and recalls.

I am happy to receive SMS reminders from the Practice. ☐ Yes ☐ No

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How did you find out about us? From a Friend or Family ☐ Online ☐ Other ☐

Once you have completed filling in this form, please return it to one of our Reception Staff.

- (This section for Nurse or GP to complete) -

Height: _____ cms **Weight:** _____ kgs **Blood Pressure:** _____