New Patient Registration Form ***Charlestown Family Medical Services***

Title:_____First Name:_____Preferred Name _____

Surname: (as shown on your Medicare Card):_____

Date of Birth: _____ □ Male □ Female □ Trans- Gender

So that we can provide you with the most relevant care for your needs, please inform us of your cultural identity.

□ Non-Indigenous □ Aboriginal □ Torres Strait islander □ Aboriginal & Torres Strait islander

□ Other cultural identity (please specify, eg. Sudanese) _____

Country of Birth: _____ Occupation:_____

Street Address: _____

Suburb: _____ Post Code: _____

Home Phone_____Work_____Mobile_____

Email: _____

Are you happy for us to send you appointment reminders and recalls by SMS? □ Yes □ No

Medicare Number: _____Position on Card_____Expiry_____

Have you registered with Medicare to participate in the *"My Health Record"* program? □ Yes □ No

If you have any of the following please provide details:
Centrelink Health Care Card Number:_____ Expiry_____

Centrelink Pension Card Number _____ Expiry _____

Veteran Affairs (DVA) Card Number _____Card Type: _____

If your DVA benefits are specific to a medical condition please specify:_____

Private Health Fund Name (eg NIB):_____

Level of Cover_____ Membership Number;_____

Next of Kin details:

Name:_____ Relationship to patient:_____

Home Phone:_____ Mobile:_____

Emergency Contact Details (this should be someone who lives locally and can assist you in an emergency)

Name:_____ Relationship to patient:_____

Home Phone:_____Mobile:_____

Name _____

MEDICAL HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS

_____

_____

_____

_____

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_____

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_____

_____

FAMILY HISTORY

(diabetes,heart disease,cancers,strokes etc)

Mother: _____

Father: _____

Siblings: _____

Other of Note: _____

_____

IMMUNISATIONS

Last Tetanus? _____

Last Flu shot? _____

Childhood Vaccinations given? Yes / No

WOMEN

Last pap smear _____

Last mammogram: _____

Do you smoke? Yes / No

Alcohol intake ___ standard drinks/week

ALLERGIES

_____

_____

_____

How did you hear about our practice?

_____

Do you currently have any community services ?eg:

Home Care, Mowing services, Meals on Wheels etc ?

CHARLESTOWN FAMILY MEDICAL SERVICES

PRIVACY & DISCLOSURE FORM

As a patient of our Practice we require you to provide us with your personal details and medical history so that we may properly assess, diagnose, manage and be proactive in your health care needs. The privacy of your health information is important to us. Your medical record is a confidential document and as such it is the policy of this practice to maintain the security of your personal health information at all times.

From time to time your personal health information may be collected, used and disclosed for the following purposes:

- Administration purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to other doctors in the Practice for the purpose of continuity of care and professional development
- For communication with others involved in your care, such as specialists and allied health providers, through referral to these services and in receiving reports or results returned to us following referral
- For service development and quality improvement activities – wherever possible all information used is de-identified. Where it is not possible to de-identify information you will be given the opportunity to "opt-out" of any involvement before your information is used
- To comply with any legislative or regulatory requirements (such as notifiable diseases)
- For notifying you about health services that may be due or which require follow-up with your GP (including inclusion on national and state registers, such as the Childhood Immunisation Register and the Pap Register)
- For legal disclosure as required by a court of law

If you have any concerns about the use of your personal health information, please speak with your GP or our Practice Manager. You may also request a copy of our Practice Privacy Policy at any time if you would like more information.

Consent:

I have read and understand the above on the collection, use and disclosure of my health information.

Your signature: _____ Date: _____

Your name: _____ Date of Birth: _____

Disclosure to Family Members

By law, if you are competent and of an age where you are capable of making decisions about your own health care, we are not permitted to disclose your medical information (including test results) to anyone else in your family without your permission. If you are 16 years or older, please indicate your consent to share and disclose your personal health information with family members:

☐ No, my information is private – only give results and other medical information directly to me

☐ Yes, my information can be shared and disclosed to the following people:

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

If you wish to change who you share your health information with, at any time, please let reception know.