Coastal Health Medical Centre
TOUKLEY

# PATIENT REGISTRATION FORM

**PLEASE COMPLETE ALL SECTIONS AND RETURN TO THE FRONT DESK**

**PATIENT INFORMATION**

| | | |
|---|---|---|
| **Title** | ☐ Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____ | |
| **Surname:** | | **First Name:** |
| **Middle Name:** | | **Preferred Name:** |
| **Date of Birth:** | / / | |
| **Sex:** | ☐ Male ☐ Female ☐ Other | |
| **Ethnicity:** | ☐ Australian (Non-Indigenous) ☐ Australian Aboriginal ☐ Australian Torres Strait Islander<br>☐ Australian Aboriginal & Torres Strait Islander ☐ Other: _____ | |
| **Street Address:** | | |
| | Suburb: | Postcode: |
| **Phone:** | Home Ph: | Work Ph: |
| | Mobile: | ☐ I do not consent to SMS appointment reminders |
| ***Workers Compensation** | Insurance Company: | Claim Number: |
| | Return To Work Officer: | Phone: |
| **Preferred contact:** | ☐ Mobile ☐ Home Phone ☐ Work Phone ☐ Email | |
| **Email address:** | | |
| **Medicare No.** | ☐☐☐☐☐☐☐☐☐☐ Ref. No. ☐ Exp. Date ___/_____ | |
| **Pension/ No.** | Exp. Date ____/_____/_____ | |
| **Pensioner card type:** | ☐ Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Senior's Card | |
| **DVA number:** | ☐ Gold ☐ White ☐ Yellow | |
| **Religion:** | | |
| **Emergency Contact:** | Name: Contact Number: Relationship to you: | |
| **Next of Kin:**<br>**Tick if same as above** ☐ | Name: Contact Number: Relationship to you: | |
| **Occupation:** | | |
| **Australian Defence Force:** | ☐ Never Served ☐ Current - Permanent ☐ Current – Reserves<br>☐ Past – Permanent or Reserves | |
| **Marital Status:** | ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed | |
| **Do You Have a Carer:** | ☐ *Yes, I have a carer ☐ No, I don't have a carer<br>***Carer's details:**<br>Name: _____ Contact Number: _____<br>Relationship to you: _____ | |

Internal office use only: Medicare card validated Yes/No V14
Health Identifier Checked Yes/No

**Family History**

Mother alive? ☐ Yes ☐ No Age at death: _____ Cause of death: _____

Father alive? ☐ Yes ☐ No Age at death: _____ Cause of death: _____

**Have you ever had a family history of:**

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes:** | ☐ Mother | ☐ Father | **Hypertension:** | ☐ Mother | ☐ Father |
| **Heart Disease:** | ☐ Mother | ☐ Father | **Stroke:** | ☐ Mother | ☐ Father |
| **Colon Cancer:** | ☐ Mother | ☐ Father | **Depression:** | ☐ Mother | ☐ Father |
| **Breast Cancer:** | ☐ Mother | | | | |

**Alcohol:**

**Current Alcohol intake:** ☐ Non-drinker

How many days a week do you drink? _____ Number of standard drinks per day: ____

**Past Alcohol intake:**

☐ Occasional drinker ☐ Moderate drinker ☐ Heavy drinker

Year started: _____ ☐ Ex-drinker: Year stopped _____

**Smoking:**

**Current Smoking history:** ☐ Non-smoker ☐ Ex-smoker ☐ Smoker

Number of cigarettes per day: _____

**Past Smoking history:**

☐ Light ☐ Moderate ☐ Heavy

Year started: _____ Year stopped _____

**Allergies:**

☐ NO Allergies ☐ Allergies **Please list any drug, food or other allergies you have:**

**Allergy**_____**Reaction**_____**Severity**_____

**Allergy**_____**Reaction**_____**Severity**_____

**Allergy**_____**Reaction**_____**Severity**_____

**How did you hear about us?**

☐ Family/Friend ☐ Website ☐ Facebook ☐ Leaflets ☐ Window signage

☐ Word of mouth ☐ Other _____

This practice is registered for the My Health Summary program which is a digital health program allowing us to easily share information between the healthcare providers involved in your care.

☐ Please tick this box if you do not consent to the My Health Summary Program

**PRIVACY STATEMENT**

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Coastal Health Medical Centre 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, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare Australia requirements
- 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 or results returned to us following the referrals
- To contact you or your family for the purposes of Recalls & Reminders

Patient information shall not be released to a third party without the expressed consent of the patient.

I have read the information above and understand the reasons why my information is collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.

Name: _____

Signed _____ Date _____