New Patient Registration Form

Jindalee Care MEDICAL PRACTICE

It is our great pleasure to welcome you to the Jindalee Care Medical Practice. We are dedicated to the highest standard of professional care for all our patients. Our aim is to partner you in maintaining your long-term health and wellbeing, this is our commitment to you.

PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS

FIRST NAME	SURNAME	MISS MS MRS MSTR MR DR	KNOWN AS
DATE OF BIRTH (i.e. DD/MM/YYYY)		MALE / FEMALE	
MEDICARE CARD NUMBER	REF NO	EXPIRY DATE	
CONCESSION CARD	REF NO	EXPIRY DATE	
VET AFFAIRS CARD NUMBER		EXPIRY DATE	
RESIDENTIAL ADDRESS			
SUBURB	STATE	POSTCODE	
HOME PHONE	WORK PHONE	MOBILE	SMS REMINDERS YES / NO
EMAIL ADDRESS			
PLEASE CIRCLE	Aboriginal	Torres Strait Islander	Both Non-Indigenous
OCCUPATION	MARITAL STATUS		
COUNTRY OF BIRTH	ETHNICITY (e.g., Caucasian, African, Asian etc.)		

DETAILS OF YOUR NEXT OF KIN
NAME
RELATIONSHIP TO PATIENT
HOME PHONE
MOBILE PHONE
EMERGENCY CONTACT
NAME
RELATIONSHIP TO PATIENT
HOME PHONE
MOBILE PHONE

Patient Consent

This medical 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, treat and be pro-active in your health care needs.

The Medical Practice may use the information you provide, in the following ways:

- Administrative purposes in running the medical practice as well as for the purposes of patient care, teaching and accreditation. This may include practice Accreditation Surveyors.
- Billing purposes, including compliance with Medicare and Health Insurance Commission.
- Disclosure to others involved in your health care, including treating doctors, specialists and allied health who work in the practice as well as outside this practice.

By signing this document, I consent to the following:

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- 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.
- By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.

PATIENT / GUARDIAN SIGNATURE	DATE

Jindalee Care
MEDICAL PRACTICE

Patient Medical History Form

PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS

FIRST NAME	SURNAME	MISS MS MRS MSTR MR DR	KNOWN AS
DATE OF BIRTH (i.e. DD/MM/YYYY)	AGE	MALE / FEMALE	

ALL PATIENTS

ALLERGIES – List any allergies and the reaction:

PAST MEDICAL HISTORY – Please list any past medical/surgical history & date of diagnosis:

MEDICATION – Please list current medications and doses:

FAMILY HISTORY – Please list any family medical history (eg heart disease, cancers):

ADULTS

ALCOHOL – **Please circle one:**

Never Monthly or less / 2-4 times a month / 2-4 times a week / 4 or more times a week

How many standard drinks in a typical day:
1 or 2 / 3 or 4 / 5 or 6 / 7 to 9

6 or more drinks on one occasion: Never / Less than monthly / Monthly / Weekly / Daily

SMOKING – **Please circle one:**
Never smoked.
Ex-smoker Quit Date:
Current smoker
Year commenced:
Cigarettes per day:

SOCIAL HISTORY –
Live with:
Extra care at home
(e.g., My aged care)
Sexuality: Heterosexual / Homosexual / Bisexual

CHILDREN (15 and under)

FAMILY DETAILS
Parent/Guardian Details:
Name:
Phone:
Name:
Phone:

IMMUNISATION
Please circle one:

Up to date / Not immunised / Unsure.

Location of immunisations:
Australia Overseas (if so, where?)

Extra vaccinations:

We acknowledge that all the above information is confidential under the Privacy Amendment Act 2000 and this will be accessed by Medical Staff Only.

PATIENT / GUARDIAN SIGNATURE	DATE