Patient Registration Form v2025

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	KNOWN AS	TITLE
DATE OF BIRTH (i.e. DD/MM/YYYY)	SEX AT BIRTH	GENDER INDENTITY	PRONOUNS
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		EMAIL COMMUNICATION YES / NO	
PLEASE CIRCLE	Aboriginal	Torres Strait Islander	Both Non-Indigenous
OCCUPATION	MARITAL STATUS	PREFERRED GP	
COUNTRY OF BIRTH	ETHNICITY (e.g., Caucasian, African, Asian etc.)		
NEXT OF KIN	PHONE	RELATIONSHIP	
EMERGENCY CONTACT	PHONE	RELATIONSHIP	

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. As part of our commitment to best care and continuous improvement of our services, we are using transcription and artificial intelligence software (Heidi) for notetaking during your consultations. Heidi is compliant with the Australian Privacy Principles and the Privacy Act.

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. We share your relevant information with your MyHealthRecord.

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 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 also aware that the doctor's at this practice uses Heidi transcription tool for patient note taking and has a privacy policy on handling patient information.
- I also understand I have an opt out option for the use of the Heidi transcription tool. I consent to the handling of my information by this practice for the purposes set out above, and the use of transcription tools by the Doctors for note taking.
- I understand that I consent to registering for **MyMedicare** which links me to this practice and my chosen GP. This is a voluntary patient registration.

PATIENT / GUARDIAN SIGNATURE: DATE:

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Patient Medical History Form v2025

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 (e.g. Penicillin – Rash):

PAST MEDICAL HISTORY – Please list any past medical and surgical history & year of diagnosis (e.g. diabetes 1998):

MEDICATION – Please list current medications and doses (e.g. Crestor 5mg at night):

FAMILY HISTORY – Please list any family medical history (e.g. father – heart attack at 50):

OCCUPATIONAL HISTORY – Any work-related health risks (e.g. construction worker – asbestos exposure):

ADULTS

ALCOHOL – **Please circle one:**
Never / Occasional / Moderate / Heavy

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, NDIS)
Sexuality: Heterosexual / Homosexual / Bisexual
Advanced Health Directive: YES / NO

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:

SCHOOL:

ELITE SPORT: YES / NO

Type of sport:

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