Jindalee Care
MEDICAL PRACTICE

OFFICE USE ONLY:
ENTERED:
DATE:

New Patient Registration Form

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 well being, 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/YY)			**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**	
EMAIL ADDRESS			
PLEASE CIRCLE	**Aboriginal**	**Torres Strait Islander**	**Both**	**Non Indigenous**
MARITAL STATUS			
OCCUPATION			
COUNTRY OF BIRTH			
ETHNICITY (e.g. Caucasian, African, Asian etc.)			

*DETAILS OF YOUR **NEXT OF KIN***	*DETAILS OF YOUR **EMERGENCY CONTACT***
NAME Mr/Mrs/Miss/Ms	**NAME** Mr/Mrs/Miss/Ms
RELATIONSHIP TO PATIENT	**RELATIONSHIP TO PATIENT**
HOME PHONE	**HOME PHONE**
MOBILE	**MOBILE**

Our practice uses a reminder system to help maintain your health. We provide our patients with preventative care and early case detection reminders e.g. Blood test results, immunisation, annual health checks, skin checks, cervical screening via an SMS system. We also utilise an SMS system for appointment reminders.

I consent to being contacted via SMS with reminders to help me maintain my health. **Yes** ☐ **No** ☐

Please be aware that you are responsible for following up any results you may have.
Results are NOT given over the phone. You will need to make an appointment with your doctor to receive your results.

Patients Signature or Parent / Guardian: _____ **Date:** _____

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NEW PATIENT REGISTRATION FORM - PATIENT CONSENT

This medical practice collects informaiton 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.

We may use the information you provide, in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclosure to other doctors, allied health workers and nurses who may work in the practice, including Locums and Accreditation Surveyors, for the purpose of patient care, teaching and accreditation

By signing this document below, I agree 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.
- 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 understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- 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.

I provide my consent for Jindalee Care Medical Practice to collect, use and disclose my personal information as outline above. I provide consent for referrals and results to be sent to a medial specialist or doctor by facsimile.

I authorise Jindalee Care Medical Practice to process my consultation fee via electronic billing with Medicare Australia, as we are a paperless practice.

Patient / Guardian Name: _____ **Date:** _____

Patient / Guardian Signature: _____ **D.O.B.** _____

Guardian Relationship: _____

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Patient Medical History Form

15 Years to Adult

PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS

Title: Mr Mrs Ms Miss Dr (please circle one)

FIRST NAME _____ **SURNAME** _____

Known as: _____ **DOB:** ____ / ____ / ____ **Sex (M/F):** _____
Day Month Year

Occupation: _____

ALLERGIES

Item: _____ **Reaction:** _____

_____

_____

PAST MEDICAL HISTORY

Please list any past medical / surgical history: _____

MEDICATION

Please list current medications: _____

FAMILY HISTORY

Please list any family medical history: _____

ALCOHOL

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week (please circle)

How many standard drinks on a typical day: 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

6 or more drinks on one occasion: Never Less than monthly Monthly Weekly Daiy or almost daily

SMOKING

Never Smoked Ex-Smoker Current Smoker (please circle one)

Year Quit _____ Cigarettes per day: _____

Year commenced: _____

SOCIAL HISTORY

Live with: _____

Extra Care at Home (eg Home Help, Meals on Wheels): _____

Marital Status: Single Married Defacto Divorced Separated (please circle one)

Sexuality: Heterosexual Homosexual Bisexual (please circle one)

Patients Signature: _____ **Date:** ____ / ____ / ____
Day Month Year

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