NEW PATIENT REGISTRATION FORM

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KINGSWAY MEDICAL CLINIC
GENERAL FAMILY PRACTICE

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other

Surname Name:_____ First Name:_____Middle Name:_____

Date of Birth: ___/ ___/ _____ Gender: _____ Occupation:_____ Marital Status: _____

Home Address:_____Suburb:_____Postcode: _____

Postal Address:_____Suburb:_____Postcode: _____ (*if different to above)*

Email: _____

Home phone number:_____Work:_____Mobile:_____

Medicare Card Number: _____ IRN: _____ Expiry: ___/___/_____

Pension, HCC, or Veterans Affairs Number (if applicable):_____ Expiry: ___/___/____

Next of Kin

Title: ____ Name: _____ Relationship to you: _____

Telephone Number: _____ Mobile Number:_____

Emergency contact *(if different to Next of Kin)*

Title:_____ Name:_____ Relationship to you: _____

Telephone Number: _____ Mobile Number: _____

Are you Aboriginal or Torres Strait Islander descent? ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Country of Birth:_____ Ethnic Origin:_____

Do you require an interpreter? ☐Yes_____ ☐ No

Allergies/Adverse Reactions/Warnings:

Do you have any allergies or are you sensitive to medications or dressings? ☐ Yes ☐ No

Medication, Dressing or substance	Reaction (eg: rash, shortness of breath, wheeze, anaphylaxis

Your Health History

Weight: _____kg Height: _____cm Waist Measurement: _____cm

Smoking History

☐ Smoker ☐ Ex-Smoker ☐ Never Smoked

Quantity/day: ☐<1 ☐1-9 ☐10-19 ☐20-39

Year Commenced:_____ Year stopped: _____

Would you like cessation advice/support: ☐

Alcohol History

☐ Non-Drinker

Days per week: _____ Standard drinks per day: _____

Past Alcohol Intake: ☐ Occasional ☐ Moderate ☐ Heavy

Year Commenced:_____ Year stopped: _____

Family History:

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Stroke ☐ Cancer ☐ Depression ☐ Others _____

Father: ☐ Diabetes ☐ Hypertension ☐ Heart disease ☐ Stroke ☐ Cancer ☐ Depression ☐ Others _____

Accommodation

☐ Own house ☐ hostel ☐ homeless ☐ rental ☐ parents' house

Are you a carer for someone at home: ☐ Is someone a carer for you at home: ☐

Medication List

Name	Dosage/ Frequency

Past procedures

Procedures	Year/ Place

Privacy Consent

Please read this consent form carefully, and sign below once you have read the following information.

This medical clinic will be collection information from you with regards to your health and well-being. We will require you to provide us with all personal details, and a full medical history so that we can properly assess, diagnose, treat and be proactive in your health care needs. We will be requiring the following information from you to provide the best care service:

- Administrative details.
- Billing information, including compliance with Medicare and Health Insurance Commission.
- Consent to other medical healthcare providers, this may include treating doctors, specialist, etc. to obtain or disclose information outside this clinic. This may occur for reasons being a request for medical tests, reports, or referrals to other doctors.
- Consent to the presence of a third party to be present during your consultation. This may include other doctors in the practice, a nurse, medical student, an interpreter, family member or a friend, Centrelink or Workcover representative etc. attached to the clinic for the purpose of patient care and well-being. Please let us know at time of consultation should you not want your medical records to be accessed for these purposes and we will make note of this in your record accordingly.
- Consent for research and quality assurance activities to improve individual and community health care and practice management, all information in these circumstances is un-identified. You will be informed when such activities are being conducted and given the opportunity to "refuse" any involvement.

I have read all the information above and understand the reasons why my information must be collected.
I am aware the clinic has privacy policy on handling patient information.
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of care and treatment given to me.
I am aware of my rights to access any medical information collected about me, except in some cases where access may be legitimately withheld. I will be given an explanation in these circumstances.
I understand should my medical history be used for any other purpose other than set out above, further consent will be obtained.
I consent to being contacted by SMS reminder, recalls, results and other messages.

Patient Name: _____ Date of Birth: _____

Signature as parent / guardian for a child _____ Relationship:_____

Signature: _____ Date:_____