



KOOBIL STREET MEDICAL
PATIENT REGISTRATION FORM (over 16yrs)

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. The purpose of this questionnaire is to help your doctor to assess your health needs. This information is treated confidentially.

Title: Dr Mr Mrs Ms Miss Other..... **Gender:** Male/Female/other

Surname: **First & Middle Names:**

Preferred Name: **Date of Birth:**

Address: **Postcode:**.....

Mobile:..... **Home:** **Work:**.....

Email:..... **Occupation:**.....

Next of Kin: Name:..... **Relationship:**.....

Phone: **Emergency Contact:** Tick if same as NOK **or**

Name:..... **Relationship:** **Phone:**.....

Medicare Number: _____	Exp: ___/___/___	Ref no:.....
Pension/Healthcare Card:	Exp: ___/___/___	
Dept of Veteran's Affairs:	Exp: ___/___/___	

Patient Background – Australia is a multicultural society. We tailor appropriate care, encourage understanding and appreciate people from different nationalities and backgrounds.

Do you identify as someone from a culturally and/or linguistic diverse background?

No Yes, please elaborate?

Do you identify yourself as: Aboriginal Torres Strait Islander Both Neither

Have you had any Operations/Procedures?

Do you have a history of any of the following?

Asthma	Diabetes	High blood pressure	Heart Problems	Cancer	High Cholesterol
Headaches	Reflux/GORD	Epilepsy	Thyroid problems	Blood clots	Bleeding problems

Please elaborate.....

Family history of any of the above? (Please list condition and relationship):

.....

Other conditions not listed:.....



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Hospital Admissions in last 12 months? No Yes:

Do you have any ALLERGIES or are you sensitive to drugs or dressing? No Yes (list):

Current Medications

Please list all current medications including over the counter medications, vitamins, etc:

When was the last time you were immunised?

Tetanus Booster <input type="checkbox"/> Yes Date: <input type="checkbox"/> No <input type="checkbox"/> Unknown	Influenza <input type="checkbox"/> Yes Date: <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pneumococcal <input type="checkbox"/> Yes Date: <input type="checkbox"/> No <input type="checkbox"/> Unknown	FOBT (faecal occult blood tests) <input type="checkbox"/> Yes Date: <input type="checkbox"/> No <input type="checkbox"/> Unknown

Social and Lifestyle

Alcohol: Non-Drinker Drinking. Number per day / per week / per month

Are you concerned about your drinking: No Yes

Smoker: No Yes. Number per day / per week

Have you tried to stop smoking No Yes: Longest time without smoking:

Ceased smoking Date: Number of years smoking:

Drug Use: No Yes: Type..... Frequency.....

Measurements (leave blank if unknown)

Height: Weight: BP: P: Last Cholesterol? years/months

Do you consent to receiving reminders via SMS? (If no, we will call to confirm appointments and send letters via mail):

Appointments YES / NO (circle) Health reminders YES / NO (circle) Recalls YES / NO (circle)

Do you consent to uploading your My Health Record (PCEHR)? YES / NO (circle)

Do you consent to receiving electronic prescriptions? YES / NO (circle)

Signature: _____ Date: ___ / ___ / _____



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Welcome to Koobil Street Medical – Privacy and Consent

Please read this **consent form** carefully prior to signing.

This general 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, and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare. This may be via letters or SMS.
- 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.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important, and we will take all steps necessary to ensure they remain confidential.

Please complete the below if you understand and agree to the following statements in relation to our use, collection, privacy, and disclosure of your patient information.

I, have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, give my permission for my personal information to be collected, used and disclosed as described above (including contact via SMS to my mobile phone number). I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient Name (Print).....Sign.....

Date:.....