The Hills Medical
FAMILY GENERAL PRACTICE

New Patient Registration Form

Please read and complete all sections and return to reception

Personal and Contact Information	
Title/Pronoun:	Surname:
First Name:	Middle Initial:
Preferred Name:	Date of Birth:
Gender at Birth:	Gender identity:
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	Work Phone:
*Email: *May be used for SMS reminders & clinical recalls	*Mobile
Country of Birth:	Ethnicity:
Cultural/Sexual/Religious Background – Is there anything we should know that will enable our practice team to remain respectful and considered during your healthcare visit?	
Emergency Contact Details	
Name:	Relationship to you:
Contact Phone Numbers:	
Next of Kin (Required)	
Name:	Relationship to you:
Contact Phone Numbers:	
Healthcare Identifiers	
Medicare Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] Ref: [ ] Expiry: _____/____	
Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White	
Concession Card Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ] Expiry: _____/_____	
Cultural Identity	
To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander? ☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander	
As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background? ☐ No ☐ Yes - Please elaborate _____ *If yes, do you require an interpreter service?* ☐ No ☐ Yes	

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Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No ☐ Yes

If Yes, provide details: _____

_____

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

_____

_____

_____

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details:

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic Illness

☐ Other – provide details: _____

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ No

☐ Ceased - date_____

☐ Yes - how many ___ day / ___ week

Alcohol

☐ No

☐ Yes - how many ___ day / ___ week / ___ month

Recreational Drug Use

☐ No

☐ Yes - type_____ frequency _____

Have any members of your family had:

☐ Heart Disease

☐ Asthma

☐ Diabetes

☐ Hypertension (high blood pressure)

☐ Mental Illness

☐ Cancer – type: _____

☐ Other significant - provide details: _____

_____

Fee Policy	The Hills Medical is **NOT a bulk billing clinic** and out of pocket fees apply. Payment in full is requested at the time of consultation. The patient will accept full liability for all **Workcover** and **TAC** claims. A $10 accounting fee will be charged if your account is not paid in full on the day of consultation
Transfer of Health Information	If you have consulted with another GP at another practice, the Health Information held by that GP may assist us with your future healthcare needs. If you wish to have a copy/summary of your health care records transferred to this clinic, please ask reception/GP for information on how this can take place.
Health Reminders & Recalls	Our medical clinic automatically provides our patients with preventative care and early detection reminders. Our clinic utilises Best Practice & HotDoc software to provide electronic communication via SMS or email regarding results, appointments and clinical reminders.
My Medicare	MyMedicare is a Government initiative to link patients with their preferred practice & practitioner to provide greater continuity of care. Would you like to register for MyMedicare? ☐ YES ☐ NO **If yes**, please ask reception team for an application form either before or after your consultation with the GP. For more information please read information provided at reception.
How did you hear about us? ***(please tick)***	☐ Family/Friend ☐ Other Health Professional ☐ Walk-in/Local ☐ Internet/HotDoc ☐ Advertising

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Patient Consent

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 the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Appointment reminders, follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS and email.
- 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 form 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 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: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____