NORTHLAKES DOCTORS

Level 1, Suite 103
North Lakes Specialist Medical Centre
6 North Lakes Drive
North Lakes Qld 4509
Telephone: 07 3204 4433
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Patient Registration Form

Patient Details

□ Dr / □ Mr / □ Mrs / □ Ms / □ Miss / □ Master

First Name:	Middle Name:	Last Name:
Address:		
Home phone:	Mobile phone:	Work phone:
Email:		
Date of Birth:	Birth Sex:	Gender Identify:

Medicare Number:	Medicare IRN:	Expiry:
DVA Card Number:	DVA Card Type □ Gold □ Silver □ White	Expiry:
Pension or Health Card Number:		Expiry:
Private Health Fund:		

Occupation: Marital Status:	Do you identify as: □ Aboriginal □ Torres Strait Islander □ Both Aboriginal & Torres Strait Islander	Ethnicity *(cultural identity which can be different from Nationality)* □ Non indigenous Australian □ Other ______________________

Medical History

Any Allergies **MUST BE COMPLETED TO REGISTER PATIENT

□ Nil known □ Allergies

Family History

Father □ Alive □ Deceased
□ Diabetes □ Colon Cancer
□ High Blood Pressure □ Depression
□ Heart Disease □ Breast Cancer
□ Stroke □ Other *(Advise GP)*

Mother □ Alive □ Deceased
□ Diabetes □ Colon Cancer
□ High Blood Pressure □ Depression
□ Heart Disease □ Breast Cancer
□ Stroke □ Other *(Advise GP)*

Smoking Status & Alcohol Intake **MUST BE COMPLETED TO REGISTER PATIENT

□ Smoker
___Number of Cigarettes per day
___Number of Tobacco (25g) pouch per week
□ Ex-Smoker
□ Non-Smoker

□ Non-drinker
□ Drink's alcohol **weekly**
__Number of days per week
□ Drink's alcohol **monthly**
__Number of days per month
□ Drink's alcohol **rarely**

Number of Standard drinks on any one occasion
□ 1-2
□ 2-4
□ 4-6
□ >6

Past History (Medical & Surgical)

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________
9. ________________________________
10. ________________________________
11. ________________________________
12. ________________________________
13. ________________________________
14. ________________________________
15. ________________________________

Current Medications

□ Nil medications
1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________
9. ________________________________
10. ________________________________
11. ________________________________
12. ________________________________
13. ________________________________
14. ________________________________

Next of Kin Contact Details

Name:	Relationship:	Contact:

Emergency Contact Details

Name:	Relationship:	Contact:

If your child is under the protection of a custody agreement or is in shared care parental care, please indicate the party/parties who may request information regarding their health care. Please provide a copy of court Agreement

Patient 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 the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by 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. Email maybe required and a copy of our full policy including risks is available at reception.
- 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.
- Our full privacy policy is available on request.

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. 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: ____ (Relationship to Patient) ______________________________

Date: ___________________________________