TINTENBAR
MEDICAL CENTRE

PATIENT REGISTRATION

MEDICARE NUMBER	**Ref. No**	**Expiry Date**
___ ____ ____ ____ ____ ____ ____ ____ ____ ____	____	_ _/_ _

DVA: __ __ __ __ __ __ __ __ GOLD/WHITE (please circle) ELIGIBLE CONDITION: (white card only)

☐ Gold ☐ White

Expiry Date _ _/_ _/_ _

CONCESSION CARD: __ __ __ __ __ __ __ __ __ __ ☐ Pension ☐ Health Care Card

☐ **DR** ☐ **MRS** ☐ **MS** ☐ **MISS** ☐ **MR**

DATE OF BIRTH _ _ / _ _/_ _

FIRST NAME: *(Known as)* **SURNAME:**

RESIDENTIAL ADDRESS	Suburb	Post Code
POSTAL ADDRESS *(If the same as above, leave blank)*	Suburb	Post Code
MOBILE PHONE	HOME PHONE	WORK PHONE
EMAIL		
OCCUPATION		

BIRTH SEX

☐ Male ☐ Female ☐ Other ☐ Unknown

GENDER IDENTITY

☐ Male ☐ Female ☐ Non-binary ☐ Gender Diverse ☐ Transgender Different Identity: _____

Were you born with a variation of sex characteristics (sometimes called 'intersex' or ' differences/discorders of sex development' ☐ Yes ☐ No ☐ Don't know ☐ Other or Prefer Not to Say _____

What are your pronouns? (tick all that apply)

☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ I use a different pronoun _____

CULTURAL BACKGROUND

Do you identify as being Aboriginal ☐ Yes ☐ No / Torres Strait Islander ☐ Yes ☐ No

Ethnicity _____

Country of Birth _____ Year you arrived in Australia? _____

Language Spoken _____

Do you require and interpreter service? ☐ Yes ☐ No

DETAILS OF YOUR **NEXT OF KIN**

NAME	
RELATIONSHIP TO PATIENT	
PHONE NUMBER (H) (M)	

DETAILS OF YOUR **EMERGENCY CONTACT**

NAME	
RELATIONSHIP TO PATIENT	
PHONE NUMBER (H) (M)	

~ Please complete all 4 pages of this form and return to reception ~

TINTENBAR
MEDICAL CENTRE

PATIENT INFORMATION

Patient name: Date of Birth:

ALLERGIES? ☐ Yes ☐ No

List any known allergies_____ Type of reaction?_____

SOCIAL HISTORY

Do you live alone? ☐ Yes ☐ No Are you the sole carer for anybody? ☐ Yes ☐ No

☐ **SMOKER** ☐ **EX-SMOKER** ☐ **NON-SMOKER**

How many cigarettes per day? _____ *Date you started smoking?*_____ *Quit date if ex-smoker?* _____

ALCOHOL

How often do you drink alcohol?

☐ NEVER ☐ MONTHLY OR LESS ☐ 2-4 x PER MONTH ☐ 2-3 X PER WEEK ☐ 4 OR MORE X PER WEEK

How many standard drinks per occasion? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 +

How often do you have 6 or more drinks? ☐ NEVER ☐ LESS THAN MONTHLY ☐ MONTHLY ☐ WEEKLY ☐ DAILY

MEDICAL HISTORY

☐Asthma ☐Diabetes ☐Osteoporosis ☐Heart Disease ☐Stroke ☐Depression ☐Cancer - type?_____

Other:_____

FAMILY MEDICAL HISTORY (Please specify) : ☐ Nil significant family history

Mother Alive? ☐ Yes ☐ No Cause of death: _____ Age?_____

Father Alive? ☐ Yes ☐ No Cause of death: _____ Age?_____

Mother: ☐Asthma ☐Diabetes ☐Osteoporosis ☐Heart Disease ☐Stroke ☐Depression ☐Cancer type?_____

Other:_____

Father: ☐Asthma ☐Diabetes ☐Osteoporosis ☐Heart Disease ☐Stroke ☐Depression ☐Cancer type?_____

Other:_____

Other family members medical history: _____

_____

Reminder systems

Our practice provides our patients with preventative care and early detection reminders such as immunisations, annual health checks, STI check and cervical screening.

Do you wish to have any relevant health reminders sent to you via Letter, SMS and phone? ☐ Yes ☐ No

Do you consent to SMS reminders for appointments? ☐ Yes ☐ No

~ Please complete all 4 pages of this form and return to reception ~

TINTENBAR
MEDICAL CENTRE

How did you find out about our surgery?

- ☐ **Word of Mouth/ Relatives**
- ☐ **Advertisements**
- ☐ **Facebook**
- ☐ **Website**
- ☐ **HotDoc / Health Engine**
- ☐ **Google**
- ☐ **Other (please specify): _____**

****Nurse Use ONLY****

BP Reading: _____ Height: _____

BSL (If necessary): _____ Weight: _____

~ Please complete all 4 pages of this form and return to reception ~

TINTENBAR
MEDICAL CENTRE

PRIVACY CONSENT

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated on the page.

This medical 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, treat and be proactive in your health care needs. We use the information that you provide us 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 with your health care, including treating doctors and specialists outside of this medical practice. This may occur through referrals to other doctors, or for medical tests and in reports returned to us following the referrals.
- Disclosure to other doctors in the practice, locums, registrars and medical students attached to the practice for the purpose of patient care and teaching.

To enable ongoing care and total quality improvement with the practice, and in keeping in with the Privacy Act March 2014 and National Privacy Principles we wish to provide you with sufficient information on how your personal health information may be used or disclosed ad record your consent or restrictions to this consent. By signing this Confidential Patient Information form, you are consenting that on obtaining your personal health information it may be utilised or disclosed by the practice for the following purposes.

1. Follow up reminder and recall phone calls/notifications for treatment and preventative healthcare
2. For accounting procedures and the collection of professional fees
3. The diagnosis and treatment of any health condition, including the communication of relevant information only to practice staff, specialists and other health care providers to ensure quality care is delivered
4. Accreditation and Quality Assurance activities are conducted by professional trained non-treating general practitioners and qualified persons, for example, general practice managers
5. For legal related disclosure as required by law
6. For disease notification as required by law
7. For use when seeking treatment by other doctors in this practice
8. For the purpose of obtaining medical records, previous clinical reports and management regimes from other practitioners, institutions, laboratories etc
9. To inform next of kin identified in my patient information of the outcome or treatment or to obtain consent to necessary treatment when I am not able to provide such consent

---

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 obligated to provide any information requested of me, but that my failure to do so might compromise the quality of my health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some cases where it might be legitimately withheld. I understand that 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.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I notify the practice.

I agree to notify Tintenbar Medical Centre of any changes of personal details as soon as they become available, such as change of address, emergency contact details, change of name etc.

Patient Name: _____

Signature: _____

Print name of Parent / Guardian signing consent (if patient under 18) : _____

DATE: ___ / ___ / __

~ Please complete all 4 pages of this form and return to reception ~