NEW PATIENT REGISTRATION FORM

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ PATIENT FULL NAME:……

Date of Birth ……/……/…… **PARENT/GUARDIAN FULL NAME**:……

Ethnicity (biological genetics eg Indian, Somalian etc) : Are you
☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Other (please note) ……..

Medicare No. **Ref number (next to name) …….**
or Vet Affairs ……..……. **Expiry ……/……...**

Pension / Health Care Card no …… **Expiry ……/……/……** **(Seniors *Circle*)**

Home Address …… **Postcode ……..**

Postal Address …….. **Postcode ……**

Phone …… **Mobile ……** **Work ……**

Email address …….. **Religion: ……..**

Emergency Contact Person: ……Relationship to you ……Ph:……..

Next of Kin:…… Relationship to you ……Ph:……..

PREFERRED COMMUNICATION: Do you consent to SMS reminders and recalls? ☐Yes ☐ No
Preferred method of communication? ☐ Phone ☐ Mail ☐ Email

Do you have private health cover? ☐ Yes ☐ No Name of Insurer ……

IMPORTANT

THIRD PARTY AUTHORITY: Should you wish for your spouse/partner or a third party to obtain information in regards to appointments, accounts, prescriptions, pathology results on your behalf, a third party authority form will be required to be completed to allow them to do so. This is also required if you will be calling on behalf of any children aged 14 years and over.

PAYMENT REQUIRED AT THE TIME OF CONSULTATION: Our practice requires payment for consultation to be made at the time of your appointment. Whereby an account cannot be paid in full on the day, the discount of $10 will not be given. Your account will be transmitted to Medicare for processing on the day and a medicare cheque will be posted to you within 14 days. You will be required to return the medicare cheque and the outstanding gap payment within 30 days of your consultation. Our preferred method of payment is via EFTPOS or credit card. Please note we are no longer able to accept personal cheques.

FAILURE TO ATTEND FEE: Our practice has a failure to attend fee of $50. This fee is only charged whereby an appointment has been made and not attended and the practice has not been notified. A minimum of 2 hours notice is required for any cancellations or changes to appointment times. No further appointments will made available whereby this fee has been charged and not yet paid.

ONLINE BOOKINGS: Appointments can be made online at **www.thedoctors.net.au** for existing patients of the practice. Confirmation of the appointment will be sent by return email (please note the system generates an automatic response and this is not the confirmation email). Cancellations or changes to the online bookings can only be made by phoning the practice on 6057 7100. Our system records all activity from this site.

ZERO TOLERANCE: Our practice has a Zero Tolerance policy for abusive or threatening behaviours directed against practice Doctors and staff or patients.
This includes but is not limited to shouting, swearing, threats, name calling, racist comments and inappropriate gestures that are deemed to be threatening, intimidating or abusive by our staff or patients. Without exception abusers will be required to leave the clinic immediately and transfer their medical care to another practice. Refusal to leave will result in the police being called.

Patient name:……..Date of Birth:……..

☐ **I consent to the use of my personal health information by The Doctors at Lavington & Thurgoona and other health providers involved in my medical treatment and health care.**
☐ **I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.**
☐**I acknowledge that I am aware and acknowledge that where a doctor has requested that I attend another provider for opinion (referral) or I am responsible for ensuring that I am aware of any fees involved for services.**
☐**Where I have bloods taken or xrays performed I am aware that I must contact the practice to ensure that the results do not require any further follow up. I understand that, in some instance, if my results indicate, I will be required to attend the practice to discuss the results with my doctor.**
☐**I am aware that the contact telephone numbers I have given will be used to send SMS reminders and if necessary Recall Notices, to make a booking to see my GP and I consent to this occurring.**
☐**I acknowledge that should my contact details change, I will advise the practice to ensure that contact can be made should follow up be required regarding any pathology or radiology.**
☐**I understand that the practice will make three (3) attempts to contact me regarding any results requiring follow up. Initially, two (2) SMN for those who consent to SMS notification and then a standard letter will be sent, or (2) telephone contact attempts and a letter, should I fail to do so myself within 7 days of the results returning to the practice. Should I fail to promptly contact the practice upon receiving the third (3rd) notification, a letter will be sent by Registered Post as a final attempt and I will be charged for the administration and postage fee $20.**

Dependants aged under 18 years to be linked to this account: (please indicate any dependant 14 years and older for whom a 3rd Party Authority form will be required)
Names and Dates of Birth:

……
……
……
……..…….

I, ……., have read and understand the above practice policies and agree to abide by these policies.
I acknowledge, that whereby I have dependents aged under 18 years of age, these policies apply to these dependants and I accept responsibility for policy adherence and payment of any fees for same.
I acknowledge that the practice may revoke my booking privileges should I fail to comply.

Signed…….Date:…….

Witnessed by Staff
Member(Name):……..Signature:……..

MEDICAL INFORMATION – Please give this form to your doctor

PATIENT FULL NAME and Date of Birth:…… ……
Please list current medications(including over the counter or vitamin/herbal medications)

Please list any allergies (include reactions to adhesive tapes if any)
Nil Known (please circle if no known allergies)

Please list any operations / previous serious illnesses :

Do you have or have you had a past history of any of the following medical conditions:

☐ **Asthma** ☐ **Epilepsy** ☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Heart Disease**
☐ **Stroke** ☐ **Colon Cancer** ☐ **Depression** ☐ **Breast cancer**

BLOOD GROUP (if known):

FAMILY & SOCIAL HISTORY

Mother alive? Yes / No **Age at death:** **Cause of death:**
Father alive? Yes / No **Age at death:** **Cause of death:**

SIGNIFICANT FAMILY HISTORY
Mother:
☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Heart Disease** ☐ **Stroke**
☐ **Colon Cancer** ☐ **Depression** ☐ **Breast cancer**
Father:
☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Heart Disease** ☐ **Stroke**
☐ **Colon Cancer** ☐ **Depression** ☐ **Breast cancer**

Other Significant Family Medical History:

FAMILY & SOCIAL:
Marital Status: Single/Married/Separated/Divorced/Widowed **Sexuality:**
Elite Athlete: Yes / No **Breast feeding: Yes / No**
Recreational Activities:

Accomodation: own home/rental/other **Lives with: Spouse/relative/friend/alone**
Has Carer (carer details):
Is Carer:

OCCUPATION:
Employer:

ALCOHOL
Current Alcohol Intake: Non Drinker ☐ Days per week _____ Standard Drinks per day:_____

Past Alcohol Intake: Nil / Occasional / Moderate / Heavy Year Started:_____Year Stopped_____

CURRENT SMOKING HISTORY
Non Smoker Yes/No Ex Smoker Yes/ No Smoker Yes/No

Past Smoking History Light / Moderate / Heavy Year Started_____Year Stopped_____