The DOCTORS at Lavington & Thurgoona

# NEW PATIENT REGISTRATION FORM

**PATIENT FULL NAME:** **Preferred Name: _____**

**Date of Birth** **PARENT/GUARDIAN FULL NAME (if pt under 18)**:

**OTHER PARENTS' NAME AND DATE OF BIRTH (if pt is under 18):_____**

**Birth Sex:** **Gender Identity:** Female/Male/Non-Binary/Gender Diverse/Transgender

**Ethnicity (Biological Genetics eg Indian, Somalian etc) :**

**Are you Australian ___ Aboriginal ___ Torres Strait Islander ___ Other (please note)_____**

**Medicare Number** **Ref number (next to name)**

**or Veteran's Affairs** **Expiry**

**Pension / Health Care Card no .** **Expiry ____/____/_____**

**Home Address** **Postcode**

**Postal Address** **Postcode**

**Phone:** **Home** **Mobile** **Work**

**Email address** **Religion: _____**

**Next of Kin:** **Relationship to you:** **Ph:**

**Emergency Contact:_____ Relationship to you:_____**

**Contact number: _____**

**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**

**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 are phoning on behalf of any children aged 14 years and over.

**PAYMENT REQUIRED AT THE TIME OF CONSULTATION:** We are no longer able to Bulk Bill. 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 is required to be paid 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-$100. This fee is only charged when 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 via our website **www.thedoctors.net.au** or by downloading the **'HOTDOC'** app for existing patients of the practice. Confirmation of the appointment will be sent by return email or SMS (please note this is an automatic response and NOT the confirmation email/sms). Cancellations or changes to all online bookings can only be made by phoning the practice on 6057 7100.

**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 to 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.

**Please sign and date**_____ **Date** _____/_____/_____

**Patient name:** **Date of Birth:**

## PATIENT CONSENT

Please read this consent form carefully prior to signing. 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 medical practice
- Billing purposes, including compliance with Medicare requirements
- Follow-up remind/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.
- 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
- 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, eg notifiable diseases
- For use when seeking treatment by other doctors in this practice
- Email correspondence will only be used if discussed and consented to by the patient

☐ 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

☐ 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, 2 SMS notifications, then a standard letter will be sent, or 2 telephone contact attempts and a standard 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 3rd notification, a letter will be sent by Registered Mail as a final attempt and I will be charged for the administration and postage fee of $20.00.

I,_____, wish to opt out of receiving SMS reminders.

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 if you will be acting on their behalf to call for test results etc)

Names and Dates of Birth:

_____
_____
_____
_____

I acknowledge, that whereby I have dependents aged under 18 years of age, these policies apply to these dependents and I accept responsibility for policy adherence and payment of any fees for same.

I, _____, have read and understand the above practice policies and agree to abide by these policies.

I, acknowledge that the practice may revoke my booking privileges should I fail to comply.

Signed _____ Date: ____/_____/_____

Witnessed by Staff Member: _____Signature: _____
Print Name

**MEDICAL INFORMATION** – Please give this form to your doctor

PATIENT FULL NAME 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 relevant)

_____

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 |
| □Psychiatric History | □Breast cancer | □Osteoporosis | □Cancer |

Diagnosed with any other significant Medical condition:_____
_____

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: _____

Accommodation: own home/rental/other: _____ Lives with: Spouse/Relative/Friend/Alone

Has a carer (carer details):_____ Is a carer for:_____

OCCUPATION: _____Employer:_____

ALCOHOL HISTORY: Non Drinker □ Drinker □ Light/Moderate/Heavy Days per week _____
Standard Drinks per day:_____ History: Age when started: _____ Age Stopped: _____

CURRENT SMOKING HISTORY: Non Smoker □ Ex Smoker □ Smoker □
Past Smoking History - Light/Moderate/Heavy Age when started: _____ Year (or age) when stopped: _____