Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

New Patient Registration Form

The Doctors and administration Staff at this clinic are committed to whole patient care. This includes preventive care as well as ongoing care. To enable The Practice to carry this out, please complete the following form. This information will be treated confidentially. Thank you for your assistance. Please return this form to the receptionist once you have finished completing it, together with your Medicare card and any concession cards.

Personal Details

Title.....First Name.....

Surname.....

Date of Birth...../...../.....

Gender Male □ Female □ Other □

Address.....

.....

Email address……

Home Phone.....Mobile Phone.....

Do you consent to be contacted by email and/or SMS:

Email: **Yes** □ **No** □ SMS: **Yes** □ **No** □

Occupation.....

Medicare number……...Number on card ……..Expiry..….....

Pension/DVA number……Number on card ……...Expiry:……..

Ethnic Background
Are you Aboriginal or Torres Strait Islander? (If yes, you may be entitled to increased Medicare benefits)

No □ Torres Strait Islander □ Aboriginal □

Your cultural background may increase your risk of certain illnesses. To help provide you with the highest standard of care, please let the practice know your cultural background and /or language.

Cultural background .....

Country of birth.....

Language.....

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

Next of Kin

Name……Phone: ……..

Relationship…….

Emergency Contact
Who should we contact in an emergency?

Name .....

Relationship .....

Phone .....Mobile.....

Marital Status

Married □ De-facto □ Single □ Widowed □ Divorced □ Separated □

Private Health Insurance

No □ Yes □: Hospital □ Extras □

Are you planning to remain a patient of this practice for at least the next 12 months?
Yes □ No □

How did you hear about our practice? ……...

Reminder System
This practice takes a preventive approach to your health. You may receive reminder letters or be reminded at your next visit of ongoing follow-up for preventive care. If you do not want to part of this system, please inform the receptionist. This correspondence may be via email or SMS text message.

Privacy
We must obtain your consent for messages to be left on your telephone answering machine or with whoever answers your phone regarding matters involving your health. We may also send SMS appointment reminders or email Reminders. Please sign below to give your consent for this to occur.

Signature .....Date.....

Please provide a photocopy of your current driver licence or other form of photo identification

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

Medical History Form

This information will be treated confidentially, and you do not have to answer any or all questions if you'd rather discuss them in person with the doctor. The information provided will help make your consultation more efficient. Please return this form in person to the doctor at the beginning of your consultation.

Full name.....

Past Medical History

.....

.....

.....

Family Medical History

.....

.....

Past Surgical History (e.g., operations, fractures etc.)

.....

.....

.....

Medications

.....

.....

.....

.....

.....

Women's Health (if applicable)

When was your last Cervical Screening Test (pap smear)?.....

When was your last mammogram?.....

How many pregnancies have you had?.....

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

Mental Health History

.....

.....

.....

Care Plan / Team Care Arrangements

Do you have a Care Plan or Team Care Arrangement currently in place?

Yes ☐ No ☐

<u>If yes, please ensure that you provide a copy of your plan</u>

If you do NOT have a copy of your plan, do you give us consent to check with Services Australia your Care Plan / Team Care Arrangement history?

Yes ☐ No ☐

Other

Do you smoke?
- ❑ Yes ..... cigs/day
- ❑ No
- ❑ Ex-smoker

Do you drink alcohol?
- ❑ Yes — How often?.....
  How many per session?.....
- ❑ No

Do you take or have you taken any other street drugs now or in the past? ❑Yes ❑No

Do you have any allergies?
- ❑ Yes .....
- ❑ No

Demographic information from this form will be input into your confidential patient record, a copy scanned into your record, and then shredded.

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

Patient Consent for Practice Communication

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) about the reminders and notification systems within this practice.

This practice is committed to providing patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with patients via SMS.

In addition to other communications, we may send you from time to time, we may send you the following types of communications:

1. Appointment reminders - notifications to remind you of upcoming appointments
2. Clinical reminders - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due
3. Clinical communications - communication to you about your clinical care such as returned pathology results or clinical messages from the doctor
4. Health awareness - communication to you about general health care information and health care services provided by this practice.

As part of the provision of healthcare services to you, we will send you appointment reminders, clinical reminders, and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications below. We may use a third-party service provider (which may be located outside of this State) and disclose your personal information to them to assist us in sending you the above communications.

Acknowledgement and Consent
I acknowledge and agree that while providing health care services to me, the practice may need to use and disclose my personal information (including any health information) as set out in this form.

I wish to receive appointment reminders for upcoming appointments	Yes	No
I wish to receive clinical reminders as described above	Yes	No
I wish to receive clinical communications as described above	Yes	No
I wish to receive health awareness communications as described above and I hereby specifically consent to the use of my personal information	Yes	No

My preferred contact method for communication is Phone Letter SMS Email

I acknowledge that the practice will use contact details provided by me (updated by me from time to time) to communicate with me. To the extent that the mobile phone number I have provided to this General Practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below to agree to the acknowledgements and consent set our above.

Patient name (please print):
Mobile phone no:
Parent/Guardian name (if Patient is under 16 years):

Signature: _____ **Date:**_____

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

Health Information Collection and Use Consent Form

As a patient of this medical practice, 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 aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.
This Practice requires your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully and sign where indicated below.

- Administrative purposes in running this medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors or for medical tests.
- Disclosure to other doctors in the practice, locums etc attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community care. This information does not identify you. If information is required that will identify you, you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements EG: notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care.

Patient to complete:
I have read the information above and understand the reasons why my information must be collected.

I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.
Yes/No

Limitations on access (if any): _____

Patient name: _____ **Date:** _____

Patient signature: _____

Signature as Guardian for a child: _____

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144
ABN: 98 366 118 942

Request to Transfer Medical Records

To be completed by the patient

Previous GP Name & Address	
Fax Number	

I hereby authorise Waratah General Practice to obtain copies of my medical records from your practice.

Full Name: **……...**

Date of Birth: **……...**

Signed: **……**

Date: **……**

We wish to advise that the patient listed above is now attending Waratah General Practice.

To ensure continuity of care, it is requested that a copy of their medical records and a Health Summary be transferred to the practice on USB (XML); sorry but we no longer accept discs.

We understand that a fee may apply and request that the patient be advised of any fees relating to the transfer of their medical records.

We would also appreciate the EPC history of the patient listed above.

To be kindly completed and returned by the previous practice

EPC Item	Completed Yes/No	Date Completed
GPMP created (721)		
TCA created (723)		
Health Assessment (701/703/705/707)		
Mental Health Plan (2710/2702)		

Please do not forward originals/paper copies - or they will be returned

Waratah General Practice
54 Station Street
WARATAH NSW 2298
Phone: 49675200 Fax: 49674144

Authorisation for Waratah General Practice to Send Emails Unencrypted

The risks of using unsecured or unencrypted email include:

- emails can easily be sent to the wrong recipient.
- email is often accessed on portable devices, such as smart phones, tablets and laptops, which are easily lost or stolen.
- emails can be forwarded or changed without the knowledge or consent of the original sender.
- email is vulnerable to interception.

Name	
Address	
Date of Birth	
Please clearly confirm your email address	

Where possible, Waratah General Practice sends emails with password protection or email communications are sent using encryption software or via a secure website.
Where the above protection is not available, with patient consent, Waratah General Practice will send emails unencrypted.

Waratah General Practice may send patient information to a generic email address where the recipient is a 3rd party e.g., Allied Health practices.

I confirm that understand Waratah General Practice's email policy.
I confirm I understand the risks of sending unencrypted emails.
I authorise Waratah General Practice to send emails that may contain my personal information to be sent unencrypted where encryption and password protection is not available.

Print name	
Signed	
Date	