Hope Skin Cancer and GP Clinic Patient Registration Form

Title (**please circle**) Dr/ Mr/ Mrs/ Ms/ Miss/ Mstr/ Rev/ Sr / Other ___________
Surname:______________________________ **First Name:**___________________________
Preferred Name:______________________ **D.O.B.**________________________________
Birth Sex: Male or female (circle) **Gender Identity:** _____________________
Pronouns He/him/his or She/her/hers or They/them/theirs (please circle)

To assist with health initiatives, are you Aboriginal? YES – NO or Torres Strait Islander? YES – NO

Do you identify as someone from a culturally and/or linguistically diverse background?
YES – NO — (if yes please elaborate) ____

Address____
Suburb:____**Postcode:**__________________

Postal Address (if different from above):
P O Box: ____________________**Suburb:**____________________________**Postcode:**_____

Home Ph. No.___________________________ **Mobile No:**_____________________________
Email Address:____

Medicare Card____________________________________ **Position**_____ **Expiry**_____/_______
Pension/concession Card______________________________ **Expiry**______/______/________
DVA ____________________ **Card Colour**_________ **(if white please note conditions below)**
____

Next of Kin
First Name ____________________________ Last Name________________________________
Phone Number___________________________ Relation__________________________________

Emergency contact (if same as NOK note 'as above')
First Name ___________________________ Last Name________________________________
Phone Number__________________________ Relation__________________________________

- **Do you allow the practice to send you APPOINTMENT SMS messages - YES / NO**
- **Do you authorise the practice to send you SMS messages for Results communication, clinical reminders and health awareness - YES/NO**

Do you have any previous illness or medical condition we need to be aware of? (please circle)

High blood pressure, Angina, Diabetes, bleeding tendency, Stomach Ulcer, Asthma, Hepatitis, cancer, Skin cancer surgery, Varicose Veins, Deep vein thrombosis, currently pregnant, HIV.

IF ANY OTHER PLEASE LIST ON NEXT PAGE

Other Illnesses

___

Do you have any allergies or are you sensitive to drugs or dressings? (if yes, please list below)

___

Do you have any family or social history that we need to be aware of such as diabetes or cancer? If so please list below.

___

DO YOU HAVE A PACEMAKER OR COCHLEAR IMPLANT? YES / NO

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent,

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes: - follow up reminder/recall notices for treatment and preventive healthcare; - for accounting procedures and the collection of professional fees; - the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;

- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. Practice Managers, Nurses;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only deidentified information;
- For disease notification as required by law;
- For use when seeking treatment by other doctors in this practice.

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.

I, ____ give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): ____

Signature: ____ Date: __________________

If not the Patient signing - your name / relationship (please print): ________________________________

How did you hear about us (eg word of mouth, newspaper, social media)? ________________________________