

Hexa Medical Centre New Patient Registration Form

PATIENT DETAILS	PATIENT MEDICAL HISTORY
Title: MR / MRS / MISS / MS / MAST / DR Surname: _____ First name: _____ Middle name: _____ Date of Birth: ____/____/____ Address: _____ _____ Post code: _____ Mobile: _____ Email : _____ Medicare number: _____ Number next to your name: ____ Expire date: ____/____/____ Aged Pension: _____ Expire: ____/____/____ Healthcare Card: _____ Expire: ____/____/____ DVA: _____ Colour: _____ Expire: ____/____/____ Occupation: _____ Country of Birth: _____ (If relevant, circle) Aboriginal / Torres strait islander Cultural/Ethnic Background 	Do you have any allergies? If so, please name and give details about reaction. _____ _____ Do you/have you suffered from any serious illness? If so, when did it start? Do you still suffer? _____ _____ Any family history of serious illness? If so, please mention relationship to you and their condition _____ _____ _____ Are you currently taking any prescription medications? If so, please mention below. _____ _____ Have you had recent immunisations, please list: _____ _____ Do you smoke? No / Yes How many per day: _____ Year started: _____ EX smoker: No / Yes Year started: _____ Year Stopped: _____ Do you drink alcohol? No / Yes Beer / Wine / Spirits Days per week: _____ How many per day : _____ How did you hear about us: Facebook Family/Friend Advertisement Website Other: _____ Emergency contact: Full Name: _____ Relationship: _____ Contact number: _____ Next of Kin contact (if different): Full Name: _____ Relationship: _____ Contact number: _____

CONSENT

We require your consent to collect personal information about you. Please read this consent form carefully and sign where indicated below.

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 pro-active in your health care needs. This means we will use the information 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 in your healthcare including treating doctors and specialists outside this medical practice. This may occur through the referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, we will note this in your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management, all information in these instances is un-identified.

You will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement.

I understand that Hexa Medical Centre with the Privacy Act (1998) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Hexa Medical Centre collecting, using, storing and disposing of my personal information to other Health Professionals to allow quality medical care, including a recall register to be advised of follow up visits, including National/State reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective employer, their authorized representative and their insurer in the case of a work related consultation or service. I also consent for the tele appointment in the future if it needs to have any. I understand that I may withdraw my consent for Hexa Medical Centre to use and disclose my personal information(except when legal obligations must be met). For medico legal reasons it is a policy of this practice that doctors have the right to request a chaperone when examining patients of the opposite sex and unaccompanied children as deemed appropriate.

Signed:.....

Name:..... Date:.....