One Care
Family Doctors

New Patient Registration

By filling out the below, you consent to One Care Family Doctors collecting and holding the following information. A copy of our privacy policy is available upon request.

1. Personal details:

Title (please circle): *Mr.* / *Mrs.* / *Ms* / *Miss* / *Mast* / *Prof.* / *Dr* / *Other* _____

Given name: _____ Surname: _____ Preferred name _____

Date of birth: ___/___/_____ Gender: *Female* *Male* *Other* *Prefer not to say*

Ethnicity:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither Country of Birth: _____

Residential Address: _____

_____

Contact Numbers: Home:_____ Mobile: _____ Work: _____

Preferred Number: *Home* / *Mobile* / *Work* Do you consent to SMS reminders? *Yes* / *No*

Email address: _____@_____

Occupation: _____

2. Health Identifiers:

Medicare No. (10 digits):

_____

IRN: _____ Expiry: _____

Concession entitlement (if applicable):

Card number: _____

Expiry: _____

Type: *Pension Card* / *Health Care Card*

DVA Entitlement (if applicable):

Card Number: _____

Card Type: *Gold* / *White* / *Orange*

3. Next of Kin / Emergency Contact

Next of Kin:

Name:_____

Relationship To You: _____

Contact number: _____

☐ May be contacted if I am unreachable

Emergency Contact:

Name:_____

Relationship To You: _____

Contact number: _____

☐ May be contacted if I am unreachable

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4. Medical history:

Cardiovascular:

- ☐ High blood pressure
- ☐ Heart attack (+/- coronary bypass / stent)
- ☐ Stroke / Transient ischaemic attack
- ☐ High cholesterol

Respiratory:

- ☐ Asthma
- ☐ Chest / lung disease
- ☐ Cardiopulmonary Disease

Other:

- ☐ Diabetes
- ☐ Kidney disease
- ☐ Blood disorder
- ☐ Arthritis
- ☐ Bowel polyps
- ☐ Bladder control
- ☐ Cancer (any type)

Neural:

- ☐ Epilepsy
- ☐ Depression / anxiety
- ☐ Mental illness

- Do you have any allergies: Yes / No _____
- Do you have any adverse reactions to medicines / other substances (such as latex/food)? Yes / No _____
- Are you currently taking any prescribed medicines? Yes / No _____
- Are you currently taking any other medicines (including over the counter; vitamins / minerals: supplements)? Yes / No _____
- Medical conditions (current or past) Yes / No _____
- Medical procedures / surgeries (current or past) Yes / No _____
- Immunisations Yes / No _____

5. Family History:

Relative	Medical condition/s?	Details?	Cause and age of death (if applicable):
• Mother	*Yes / No*	_____	_____
• Father	*Yes / No*	_____	_____
• Brother	*Yes / No*	_____	_____
• Sister	*Yes / No*	_____	_____
• Other	*Yes / No*	_____	_____

6. Social History:

Tobacco: ☐ Non- Smoker or _____ per day / week or date cessed smoking ___

Alcohol: ☐ Non- Drinker or _____ per day / week or date cessed drinking ___

7. Patient Consent:

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

This general 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 and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 information is used or disclosed. The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare 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/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 general practice.**
- **Billing purposes, including compliance with Medicare requirements.**
- **Follow-up reminder/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.**
- **For the purposes of research only where de-identified information is used.**
- **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, e.g. notifiable diseases.**
- **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.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

Patient name: _____ **Signature**:_____

Date: _____

Name- If not patient signing:_____ **Relationship to patient**: _____

OFFICE USE ONLY:

Entered into B.P **Yes / No** **Date:** _____ **Initials:** _____ **Doctor:** _____

Rechecked/Validated **Yes / No** **Date:** _____ **Initials:** _____

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Please return this form to reception once completed.