New Patient Registration Form

Welcome to Health Yeppoon. If you have any questions, please ask our staff.

Title:	Surname:	First Name:	
Preferred Name:	DOB:	Birth Sex:	Gender Identity:
Street Address:			
Suburb:	Post Code:	Occupation:	
Postal Address (if different):			
Home Ph:	Work Ph:	Mobile:	
Email:			
Australian (not Indig.) □ Aboriginal origin □ Torres Strait Islander origin □ Other □ _____			
Medicare No:	__ __ __ __ __ __ __ __ __ __ Ref No: __ Exp: __ / __		
Concessions:	Pension □ Health Care Card □	__ __ __ __ __ __ __ __ __ __ Exp: __ / __ / __	
Veterans:	DVA No:	Gold □ White □ Conditions:	
Next of Kin:	Ph:	Relationship to you:	
Emergency Contact:	Ph:	Relationship to you:	

Health Yeppoon collects information from you to assist us in providing quality health care. We require your personal details and your medical history so that we may properly assess and manage your health and enable us to be 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.

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 running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare. We may contact you via email or SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice, and national bodies i.e. immunisation register.
- Accreditation, research, and quality assurance activities to improve individual and community health care and practice management. This is usually de-identified, however if any information that could identify you is required, you will be informed and given the opportunity to “opt out”.
- For legal related disclosure as required by a court of law.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.

Please sign if you have read and understand the information above, and give your consent to participate:

Signature: _____ Patient/Guardian name: _____ Date: __ / __ / __

Please turn over

Medical History:

Do you have any allergies? Please list: ……
……..

Do you take any regular medications/vitamins? Please list: ……
……..

Do you have any medical conditions? Please list: ……..
……..

Have you ever had any operations? Please list: ……
……..

Are there any other specialists or allied health professionals involved in your care? ……...
……..

Have you ever been a smoker? Yes □ No □ Do you currently smoke? Yes □ No □

How much do you smoke per day? ….. If none, when did you quit? …….

Do you drink alcohol? Yes □ No □ If yes: …… days per week , …… drinks per day

Have any members of your family had: (please note whom and approximate age)

Heart disease: ……..

Stroke: ……

Diabetes: ……

Cancer (please list which): ……

Other: ……

Is there any information that you believe we should know that may affect or have an influence on the medical treatment / advice you will be provided with?

If yes, please provide details: ……
……..
……..

Previous GP: …… at ……..