



# PATIENT REGISTRATION FORM

Welcome to Grand Pacific Health Centre - Nowra.

Thank you for completing these forms.

Please read and complete all pages.

GPHC Nowra - regular patient  One off visit

Allied health provider only.

Mr  Mrs  Ms  Miss  Master

Surname .....

First name .....

Middle name .....

Preferred name .....

Date of birth \_\_\_ / \_\_\_ / \_\_\_

Male  Female

Cultural Background

- Aboriginal Australian
- Torres Strait Islander
- Aboriginal & Torres Strait Islander
- Australian
- Other

Other (please specify) .....

Do you require an interpreter? Yes  No

Religion .....

Patient occupation or, if retired, previous occupation .....

## ADDRESS

Home address .....

Postal address (if different) .....

## CONTACT PHONE NUMBERS

Home .....

Mobile .....

Work .....

Email .....

Do you agree to SMS appointment reminders? Yes  No

Medicare number \_\_\_\_\_

Ref number (next to patient name) \_\_\_\_

Medicare expiry date \_\_\_ / \_\_\_ / \_\_\_

### OR

Vet Affairs number \_\_\_\_\_

Gold card  White card

Vet expiry date \_\_\_ / \_\_\_ / \_\_\_

Do you have a Pensioner Concession Card? Yes  No

Card number \_\_\_\_\_

Card expiry date \_\_\_ / \_\_\_ / \_\_\_

Do you have a Health Care Card? Yes  No

Card number \_\_\_\_\_

Card expiry date \_\_\_ / \_\_\_ / \_\_\_

Do you have private health insurance? Yes  No

Health fund name.....

## 1ST EMERGENCY CONTACT

Next of kin .....

Relationship .....

Phone .....

Mobile .....

## 2ND EMERGENCY CONTACT

Name .....

Relationship .....

Phone .....

Mobile .....

Do you have My Health Record? Yes  No

Would you like to register for My Health Record? Yes  No

**MEDICAL HISTORY**

Allergies Yes  No

Please list .....  
.....

Please tick if you have any of the following conditions:

- Anxiety
- Arthritis
- Asthma
- Cancer
- Type .....  
.....
- Chest pains
- Cholesterol
- Dementia/Alzheimer's
- Depression
- Diabetes  Type 1  Type 2
- Digestive/bowel disorders
- Discomfort in legs
- Dizziness/fainting
- Emphysema
- Epilepsy
- Gall bladder infection
- Hearing impairment
- Heart condition
- Hepatitis
- Hernia
- High blood pressure
- Liver condition
- Low blood pressure
- Mental health condition
- Kidney disease
- Osteoporosis
- Parkinson's disease
- Stroke
- Thyroid disease
- Taking thyroid medication
- Vision impairment

Please provide details or list other history (including broken bones)

.....  
.....

Operations .....  
.....  
.....

For women, year of last Pap smear .....

**SMOKING STATUS**

Non smoker

Ex smoker  Quit date .....

Smoker  Smokes per day .....

Year started .....

Want to quit? Yes  No  Thinking about it

**ALCOHOL INTAKE**

Non drinker

Days per week.....

Less than monthly

How many standard drinks per day? .....

**SOCIAL HISTORY**

Single  Married  De facto  
 Separated  Divorced  Widowed

Heterosexual (*straight*)  Homosexual (*gay*)  
 Bisexual (*both*)  Transgender  
 Intersex

**PHYSICAL ACTIVITY**

Are you an elite athlete? Yes  No

Do you exercise for at least 30 minutes a day? Yes  No

Do you have a carer? Yes  No

Are you a carer? Yes  No



**FAMILY HISTORY**

Mother alive? Yes  No  Age at death: .....  
Cause .....

Father alive? Yes  No  Age at death:.....  
Cause .....

Has anyone in your family had (includes grandparents, father, mother, siblings, aunts and uncles - please specify who and indicate if they are maternal (mother's side - M) or paternal (father's side - P):

Asthma No  Yes  Who: ..... M / P

Bowel cancer No  Yes  Who: ..... M / P

Breast cancer No  Yes  Who: ..... M / P

Diabetes No  Yes  Who: ..... M / P

Depression No  Yes  Who: ..... M / P

Heart disease/ heart attack No  Yes  Who: ..... M / P

High blood pressure No  Yes  Who: ..... M / P

Stroke No  Yes  Who: ..... M / P

Family history of other conditions/diseases .....  
.....  
.....

Is this form for a child? Yes  No

**I believe the above to be a true account of my health information.**

Signature: .....

Name: : .....

Relationship:  Self  Parent/carer  Translator

Date .....

**HEALTH INFORMATION COLLECTION AND USE CONSENT FORM**

Please read this consent carefully, and tick or sign where indicated.

As a patient of our medical practice we require you to provide us with your personal details and a full medical history so that we can properly assess, diagnose, treat and be proactive in your health care needs.

We aim to collect information directly from you, wherever possible. We may also need to collect information from other health professionals who have treated you. In an emergency we may also need to collect information from a family member, friend, carer or other person who can help us to provide you with the best care.

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.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to other health providers in the practice, locums etc, attached to the practice for the purpose of patient care and teaching.
- Disclosure to other health providers involved in your care.
- For research and quality assurance activities to improve individual and community health care and practice management. Information that does not identify you is used but should information that will identify you be required 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 to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

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 third party.

Signature: .....

Print Name .....

I am unsure and would like to discuss this further with someone from the medical practice before I sign.