The Lismore Clinic
Your partner in good health

New patient registration form

We need this information to provide the best quality care.

Please print letters
Use black or blue pen
Place ☑ in all applicable boxes

This form complies with the RACGP Standards for General Practice. This means your health information is kept private and secure, as required by federal and state privacy laws.

If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allows us to contact you promptly about tests and results.

Section A: Personal Details

Title | Surname | Given Names

Date of birth (dd/mm/yy) / / | Gender Male ☐ Female ☐ Not stated ☐ | Marital Status

Medicare Card no. | Medicare ref no. | Medicare card expiry date / /

Pension, Health Care Card, or Veterans Affairs no. (if applicable) | Type of Veterans: | Expiry / /

Occupation

Home address | Postcode

Potal address | Postcode

Telephone number | Work number | Mobile number

Who can we contact in an emergency?

Name | Relationship to you

Telephone number | Work number | Mobile number

Is your next of kin the same as you emergency contact?

Yes ☐ No ☐ Name

Relationship to you | Telephone number | Mobile number

Do you have an Advanced Health Care Directive for end of life care?

Yes ☐ No ☐ For more information talk to your GP

Would you like a copy of our Privacy Policy?

Yes ☐ No ☐

Section B: Cultural background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you Aboriginal or Torres Strait Islander origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐ ATSI ☐

If YES (ATSI) are you registered for the "Close the Gap" program?

Yes ☐ No ☐

Other cultural background (eg: Mediterranean, Asian, African) | Country of birth

Primary language | Do you require an interpreter?

Children under 14 need to have an adult as the Primary Account Holder as Medicare will not accept claims for children. Please indicate who is the legal guardian

Emergency contact ☐ Next of kin ☐ If neither who?

Name | Date of birth / / | Telephone

Medicare Card no. | Medicare ref no. | expiry date / /

Section C: Allergies and medicines

List allergies and intolerances to medications	Describe your reactions

List of regular medications and doses

Section D: Your health history

Alcohol: Never ☐ Monthly ☐ 2-4 times per month ☐ 4 or more times ☐

How many standard drinks per day

1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 + drinks ☐

Tobacco: I have never smoked ☐ Ceased smoking ☐ what year

How many smokes per day? | Height | Weight

If 50 years or older, have you had a test as part of the National Bowel Cancer Screen Program?

Yes ☐ No ☐

Do you suffer from, or are you affected by, any of the following?

Diabetes Yes ☐ No ☐ Hypertension Yes ☐ No ☐

Asthma Yes ☐ No ☐ Chronic illness Yes ☐ No ☐

Other

Past operations

date		details	
date		details	

Females : When did you last have a

Cervical smear	date		Not sure ☐	Never ☐
Breast check	date		Not sure ☐	Never ☐
Mammogram	date		Not sure ☐	Never ☐

Family History: Please list any members of your family who have been diagnosed with

Diabetes	Yes ☐	
Asthma	Yes ☐	
Heart Disease	Yes ☐	
Cancer (please state type)	Yes ☐	
Other	Yes ☐	

Children's Immunisations

If completing this form for a child, are their immunisations up to date?

Yes ☐ No ☐

Section E: Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, telephone or SMS for procedures such as cervical smears and other health reviews.

I consent to being contacted with reminders to help me maintain my health.

Yes ☐ No ☐

Our practice participates in the National Digital Health Record System. MyHealth record is a secure online summary of your health information. You can control what goes into it, and who is allowed access to it. You can choose to share your health information with your doctors, hospitals and other health care providers.

I consent to a MyHealth record, shared health summary being uploaded to help me maintain my health.

Yes ☐ No ☐

Thank you for providing us with the information which will allow us to provide you with a high standard of medical care.

Signature of patient or guardian

Date

/ /

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can happen.

The Lismore Clinic
Your partner in good health

Health information collection & Use Consent Form

Patient Privacy is important to The Lismore clinic. We respect your rights and ensure all personal and health information remains private and confidential. Your health information refers to information pertaining to your health, medical history, and past and future medical 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 procedures, 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 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, registrars, locums etc attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually 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.
- Where legally required to do so, such as producing records to court, mandatory reporting of child abuse.

Please read this consent form carefully, and sign where indicated below.

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

I undertand 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 circumstamces. ☐

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 this practice. ☐

OR

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

Patient/Guardian name	**Signature**	**Date**
		/ /