The Lismore Clinic
Your partner in good health

New patient registration form

Title (please circle) Dr/ Mr/ Mrs/ Ms/ Miss/ Mstr/ Rev/ Sr

Given Names: _____ **Surname**: _____

Preferred Name: _____

Date of Birth: _____ **Gender: Please tick** □ **Male** □ **Female** □ **Other**

Street Address: _____

Suburb: _____ **Postcode**: _____

Postal Address (if different from above):

P O Box/Street: _____

Suburb: _____ **Postcode**: _____

Mobile No: _____ **Home Ph. No**. _____

Work Ph. No. _____

Email Address: _____

Occupation:_____

Please present to Staff if relevant:

Medicare Card : _____ (___) exp:_____ **DVA:** _____

Health Care Card: _____ **Pension Card:** _____

Do you identify as someone from a culturally and/or linguistically diverse background?

□ **YES – please elaborate** _____

To assist with health initiatives, are you Aboriginal or Torres Strait Islander? Please tick:

□ **Aboriginal** □ **Torres Strait Islander** □ **Aboriginal & Torres Strait Islander** □ **No**

Do you require an Interpeter? _____

Country of Birth: _____

Do you authorise the practice to send you SMS appointment confirmations? YES / NO

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and Pap smears

Do you wish to have any relevant reminders sent to you?

□ **Yes – via mail** ***OR*** □ **Yes – SMS to this ph no:** _____ □ **No**

If we need to contact you, what is your preferred method of contact?

□ **Home Phone** □ **Mobile Phone** □ **Mail**

Next of Kin

First Name: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Emergency Contact

First Name: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Do you have any previous illness or medical condition we need to be aware of (tick below)?

□ High blood pressure	□ Angina	□ Diabetes
□ Bleeding tendency	□ Stomach Ulcer	□ Asthma
□ Hepatitis	□ Skin cancer surgery	□ Varicose Veins
□ Deep vein thrombosis	□ Currently pregnant	□ HIV
□ Heart valve surgery	□ Other – provide relevant details below	

_____

_____

Do you have any allergies or are you sensitive to drugs or dressings:

□ **Yes (if yes, please list below)** □ **No**

_____

_____

Please inform your GP of your health history: eg – smoking status, alcohol intake, list of regular medication and your reactions, past operations, family history, children's immunisation status.

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes from consultations, 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;

- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- 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.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
Patient (please print): _____
Signature: _____ Date: _____
If not the Patient signing – Your name (please print): _____

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

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.