NEW PATIENT REGISTRATION FORM

|  |  |
| --- | --- |
| **Please print letters****Use black pen****Tick all applicable boxes** | We need this information to provide the best quality care. This form complies with the RACGP Standards for General Practices. Your personal information is kept private and secure, as required by state and federal laws. **If you have any concerns, please leave blank and discuss with your GP, Nurse, or Reception staff.** |

# Section A: **New patient information**

## Please complete all sections to the best of your ability. Accurate contact details help us identify you and your medical records, and allow us to contact your promptly. Please notify us promptly of any changes to your details.

## **Personal details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title  |  | Given names  |  | Surname  |
|  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| D.O.B. (dd/mm/yyyy) |  | Sex at birth  |  | Gender identity  |  | Pronouns  |  | Ethnicity |
|  / / |  |  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mobile ph |  | Home ph |  | Work ph |
|  |  |  |  |  |

|  |  |
| --- | --- |
| Street address  |  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb  |  | Post code  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email  |  | Occupation |  |
|  |  |  |

## **Medicare and Concession Cards**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medicare number  |  | Reference |  | Expiry (mm/yyyy) |
|  |  |  |  |  / |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pension or Health Care Card number (if applicable) |  | Reference |  | Expiry (dd/mm/yyyy) |
|  |  |  |  |  / / |

|  |  |  |  |
| --- | --- | --- | --- |
| Veteran’s Affairs number (if applicable) |  | Colour |  |
|  |  |  |

## **Emergency contact and Next of kin**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Relationship  |  | Contact number |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | Relationship  |  | Contact number |
|  |  |  |  |  |

# Section B: **Cultural background**

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

Are you of Aboriginal or Torres Strait Islander origin?

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No |  |  | Aboriginal |  |  | Torres Strait Islander |  |  | Both Aboriginal and Torres Strait Islander |  |

|  |  |  |
| --- | --- | --- |
| Other cultural background  |  | Country of birth |
|  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Is English your first language  | Yes |  |  | No |  |

 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Do you require an interpreter? | Yes |  |  | No |  |

 |

|  |  |
| --- | --- |
| Languages other than English  |  |

# Section C: **Allergies and medications**

|  |  |  |
| --- | --- | --- |
| List any **allergies and intolerances** to medications  |  | Describe your **reaction** |
|  |  |  |
|  |  |  |
|  |  |  |

List any **regular medications and doses**, and complementary medications and doses

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# Section D: **Consent for reminders**

Our practice uses a reminder system to help maintain your health. The practice may use post, email, telephone, or SMS reminders for procedures such as vaccinations, cancer screenings, care plan renewals, and other health reviews requested by your Doctor or Nurse. The practice also sends information to the Australian Immunisation Register, National Cancer Screening Register, and Primary Health Care Network (deidentified information).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **I consent to being contacted with reminders to help me maintain my health**  | Yes |  |  | No |  |
| Signature of patient (or guardian if under 16) |  | Date (dd/mm/yyyy) |
|  |  |  / / |
|   |  |  |

# Section E: **Transfer of medical records**

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us providing continuity of care. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask reception for further information

# Section F: **Practice Policy Agreement**

BY BECOMING A PATIENT OF CHATSWOOD ROAD MEDICAL CENTRE AND SIGNING BELOW, I HAVE READ AND AGREE TO THE FOLLOWING:

* Standard appointments are **10 minutes** and generally cover **one health concern**. If you have more than one health concern, a complex health issue, or require a longer appointment for any other reason please **notify reception at the time of booking**. A separate appointment must be made per person/family member. This will assist the doctors with running on time.
* An appointment must be made with a doctor to **obtain results, repeat prescriptions or referrals**. Results will not be given over the phone.
* Please ensure mobile phones are turned off during the consultation.
* Patients who **fail to attend** a scheduled appointment **may incur a $75 fee** and will be unable to attend the practice until the account is paid. **Failure to cancel or reschedule appointments** more than **30 minutes before** the scheduled appointment time will be considered **failed to attend**.
* Patients who are **late** to their appointment may have to **wait** until other patients who arrived on time are seen or in some cases **reschedule** the appointment altogether; this is at the discretion of the doctor.
* Doctors at this practice **do not prescribe schedule 8 drugs** and have a **no-tolerance policy to doctor shoppers** **and drug seekers**. Doctors have the right to refuse the request for prescription drugs.
* This practice has a **no-tolerance policy for aggressive or abusive behaviour**. Patients who are physically or verbally aggressive to staff will be **banned** from the practice **effective immediately**.
* It is at the discretion of the doctor and practice staff to provide personal health information to parents/guardians of patients under the age of 16. All patients **16 and over are considered adults** and **information will not be disclosed to parents/guardians/friends/spouse without permission** from the patient. If you would like to nominate a person to have access to your health information and communicate with us on your behalf please ask reception for a **Third Party Access Consent form**.
* The Practice has a **Privacy Policy** in place which is available on request. This policy will state how we will deal with all personal and sensitive information which includes health information in a confidential and professional manner.
* I understand - by indicating by signing below - that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

I HEREBY CONSENT TO THIS POLICY AGREEMENT

|  |  |
| --- | --- |
| NAME OF PATIENT |  |
|  |
| SIGNATURE OF PATIENT (OR GUARDIAN IF UNDER 16) |  |
|  |
| NAME OF GUARDIAN  |  |