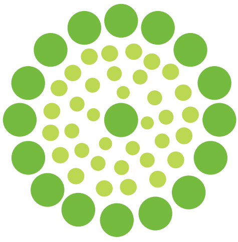


Shell Cove
FAMILY HEALTH

PATIENT REGISTRATION FORM

Welcome to Shell Cove Family Health and thank you for completing these forms.
It makes it much easier for us to care for you or your family member.

Please read and complete all pages.

Office use

☐ SCFH - regular patient

☐ Accessing allied health provider /Gym Services 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)* ....

Religion ....

ADDRESS

Home address ....

....

....

Postal address *(if different)* ....

....

....

CONTACT PHONE NUMBERS

Home ....

Mobile ....

Work ....

Email..

Do you agree to SMS appointment reminders? Yes ☐ No ☐

Your occupation or, if retired, previous occupation

....

Medicare number ________________________________

Ref number *(next to your 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..

Do you have extras cover? Yes ☐ No ☐

I would like assistance with creating my e-Health record by a member of staff Yes ☐ No ☐

Next of kin ....

Relationship ....

Phone ....

Mobile ....

2ND EMERGENCY CONTACT (DIFFERENT TO NEXT OF KIN):

Name ....

Relationship ....

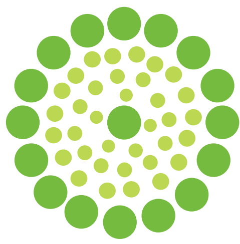
Phone ....

Mobile ....

Is this form for a child? Yes ☐ No ☐

Grand Pacific Health acknowledges support received from the Australian Government Department of Health.

Grand Pacific Health



Shell Cove
FAMILY HEALTH

MEDICAL HISTORY

Allergies Yes ☐ No ☐

Please list ………………………………………………………………

………………………………………………………………………………

Please tick if you have any of the following conditions:

- Anxiety ☐
- Arthritis ☐
- Asthma ☐
- Cancer ☐
  Type ………………………………………………………………………
- Dementia/Alzheimer's ☐
- Depression ☐
- Diabetes ☐ Type 1 ☐ Type 2 ☐
- Emphysema ☐
- Gall bladder infection ☐
- Hearing impairment ☐
- Heart condition ☐
- Hepatitis ☐
- High blood pressure ☐
- Low blood pressure ☐
- Kidney disease ☐
- Osteoporosis ☐
- Parkinson's disease ☐
- Stroke ☐
- Thyroid disease ☐
- Taking thyroid medication ☐

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

………………………………………………………………………………

………………………………………………………………………………

Operations ……………………………………………………………

………………………………………………………………………………

………………………………………………………………………………

………………………………………………………………………………

For women - last Pap smear …………………………………………

SMOKING STATUS

Non smoker ☐

Ex smoke ☐ Quit date ……………………

Smoker ☐ Smokes per day …………

Year started ……………………………………………

Want to quit? Yes ☐ No ☐ Thinking about it ☐

ALCOHOL INTAKE

Non drinker ☐ Days per week ……………………………………

How many standard drinks per day? ……………………………

Less than monthly ☐

SOCIAL HISTORY

☐ Single ☐ Married ☐ De facto

☐ Separated ☐ Divorced ☐ Widowed

☐ Homosexual *(gay)* ☐ Heterosexual *(straight)*

☐ Bisexual *(both)* ☐ Transgender

☐ Intersex

PHYSICAL ACTIVITY

Are you an elite athlete?	Yes ☐	No ☐
Adult: Do you exercise for at least 30 minutes a day?	Yes ☐	No ☐
Child: Do you spend more than 1 hour in front of the TV/computer most days?	Yes ☐	No ☐
Do you have a carer?	Yes ☐	No ☐
Are you a carer?	Yes ☐	No ☐

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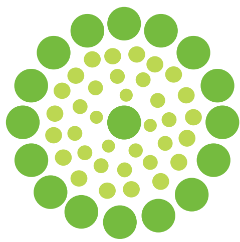

FAMILY HISTORY

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 or paternal by circling M or P):

Condition	No	Yes	Who	
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

Other conditions/diseases

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

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

Signature: ……………………………………………

Name: : ……………………………………………

Relationship: ☐ Self ☐ Parent/carer ☐ Translator

Date ……………………………………………

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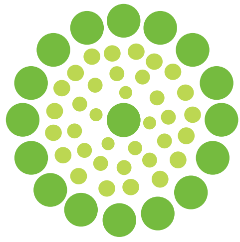
Grand Pacific Health



Shell Cove
FAMILY HEALTH

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

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

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to other doctors in the practice, 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.
- 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 of 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.

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Grand Pacific Health

Shell Cove
FAMILY HEALTH

SHALLOWS LIFESTYLE CENTRE REGISTRATION FORM AND PRE-EXERCISE SECTION ONLY

What do you want to achieve from your exercise program/gym membership?
……
……
……
……
……
……
……
……
……
……
……
……
……
……

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

I acknowledge that participation in exercise can carry some risk to my health and that it is my responsibility to assess my level of fitness, identify any medical conditions that i suffer from and seek appropriate medical advice where necessary, prior to partaking in exercise. I herby certify that i am not aware of any medical condition (except those which i have specifically brought to the attention in this document) that may increase the risk of illness or physical injury to me as a result of my participation in this program.

Patients Signature…………………………………………………

Patients Name…………………………………………………

Date…………………………………………………

Carer/guardian Signature…………………………………………………

Carer/guardian Name …………………………………………………

Date…………………………………………………

INTERNAL USE ONLY

❑ 'At Risk' if answer YES to any of the 7 questions, medical clearance is required

Comments:……
……
……

Print Name:……

Signed: ………

Date:……

Grand Pacific Health acknowledges support received from the Australian Government Department of Health.

Grand Pacific Health