

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):

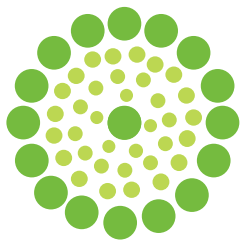
Name .....

Relationship .....

Phone .....

Mobile .....

Is this form for a child? Yes  No



**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)

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Operations .....

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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**

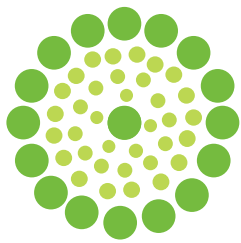
Are you an elite athlete? Yes  No

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 ):

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 .....



**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.

Patient's signature: .....

Carer/guardian signature: .....

Patient's name: .....

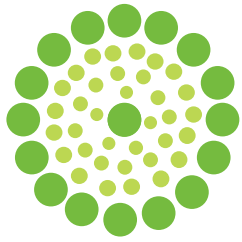
Carer/guardian name: .....

Date: .....

Date: .....

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





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# SHALLOWS LIFESTYLE CENTRE REGISTRATION FORM AND PRE-EXERCISE SECTION ONLY

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

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**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 hereby 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..... Carer/guardian Signature .....

Patients Name ..... Carer/guardian Name .....

Date ..... Date .....

**INTERNAL USE ONLY**

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

Comments:.....

.....

.....

Print Name:.....

Signed: .....

Date:.....

