Shell Cove
FAMILY HEALTH

PATIENT REGISTRATION FORM

Welcome to Shell Cove Family Health and thank you for completing this form.
It makes it easier for us to care for you or your family member.
Please be careful to read and complete both pages in full.

SCFH - regular patient ☐ One off visit ☐
Allied health provider 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)*: .....

Do you require an interpreter? Yes ☐ No ☐

Religion: .....

Patient occupation or, if retired, previous occupation

.....

ADDRESS

Home address: .....

.....

.....

Postal address (if different): .....

.....

CONTACT PHONE NUMBERS

Home: .....

Mobile: .....

Work: .....

Email: .....

Do you agree to SMS appointment reminders?

Yes ☐ No ☐

Medicare number: _____

Ref number (next to patient name): _____

Medicare expiry date: _____ / _____

OR

Vet Affairs number: _____

Gold Card ☐ White Card ☐

Vet expiry date: _____ / _____

Do you have a Pension Concession Card? Yes ☐ No ☐

Card number: _____

Card expiry date: _____

Do you have a Health Care Card? Yes ☐ No ☐

Card number: _____

Card expiry date: _____

1ST EMERGENCY CONTACT

Name: …….....

Relationship: .....

Phone: .....

Mobile: .....

2ND EMERGENCY CONTACT

Name: .....

Relationship: .....

Phone: .....

Mobile: .....

MEDICAL HISTORY

Allergies Yes No

Please list: .....

Please provide details of any medical history (Please ask for extra paper if required): ……....

.....

SMOKING STATUS

Non-smoker ☐ Smoker ☐

Ex-smoker ☐ Quit date: _ _ /_ _ /_ _ _ _

Smokes per day: ..... Year started: .....

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

ALCOHOL INTAKE

Non-drinker ☐ Drinker ☐

Days per week: .....

How many standard drinks per day? .....

SOCIAL HISTORY

Single ☐ Married ☐ De facto ☐

Separated ☐ Divorced ☐ Widowed ☐

Heterosexual (straight) ☐ Transgender ☐

Homosexual (gay) ☐ Intersex ☐

Bisexual (both) ☐

FAMILY HISTORY

Mother alive? Yes ☐ No ☐ Age at death: .....

Cause: .....

Father alive? Yes ☐ No ☐ Age at death: .....

Cause: .....

Has anyone in your family had (please indicate if they are maternal (mother's side - M) or paternal (father's side - 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

Family history of other conditions / diseases: .....

……

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

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

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.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to other health providers in the practice, locums etc., attached to the practice for the purpose of patient care and teaching.
- Disclosure to other health providers involved in your care.
- For research and quality assurance activities to improve individual and community health care and practice management. 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 e.g. 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 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 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 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.