NEW CLIENT REGISTRATION FORM

We need this information to provide the best quality care. Our practice follows the guidelines of the Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP. This form complies with the RACGP Standards for general practice.

CLIENT'S DETAILS *(Circle or highlight where appropriate)*

Title: _____ First Name: _____ Last Name: _____

Middle Name: _____ Date of Birth: _____ / _____ / _____ *Male / Female*

Preferred Name: _____

Marital Status: *(circle) Single Married Defacto /Separated Divorced Widowed*

Ethnicity: *(circle) Aboriginal Torres Strait Islander Non-Indigenous*

Both Aboriginal & Torres Strait Islander

Do you speak any other languages other than English? ***Yes / No***

Do you need an Interpreter? ***Yes / No*** *(if YES provide details)* Language _____

Address:
Home: _____ Post Code: _____

Postal: *(If different to above)* _____Post Code: _____

Phone: (home): _____ (work): _____ (mobile): _____

Medicare Card / Private Health / Health Care Concession Card / NDIS:

Medicare Number: _____ Ref on Card: _____ Expiry Date: _____ / _____

Private Health Fund: ***Yes / No*** *(if YES provide details)*

Fund Name: _____ Number: _____Expiry Date: ____ /____ /____

Health Care/ Concession Card: ***Yes / No*** *(If YES circle the relevant card below, provide details)*

Pensioner Concession Card Health Care Card Seniors Health Card Veterans Affairs Card

Reference Number: _____ Start Date: ___/_____/___ Expiry Date: ___/_____/___

Are you Registered for **NDSI**? ***Yes / No*** *(if YES provide details)*

NDIS Number: _____Plan Start Dart: ____/____/____ Plan End Date:____/____/____

Emergency Contact:

Full Name: _____ Relationship to you: _____

Phone (home): _____ (work): _____ (mobile): _____

Is this person also your **Next of Kin**? ***Yes / No*** *(if NO fill out second emergency contact)*

Second Emergency Contact:

Full Name: _____ Relationship to you: _____

Phone (home): _____(work): _____(mobile): _____

Do you have any known allergies or current medical conditions? ***Yes / No*** *(If YES please explain)*

_____

_____

Our practice undertakes research, professional development and quality assurance/ improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed as part of the quality improvement activities at this practice. ***Yes / No***

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone and text for procedures such as vaccinations, Pap tests and other health reviews.

I consent to being contacted with reminders as part of the quality improvement activities at this practice.
Yes / No

I consent to Medical/ Nurse/ Aboriginal Health Worker students being present during my consultations.
Yes / No

I consent to the health care providers holding case conferences when it is identified that a multidisciplinary team approach will be beneficial to my health care needs.
Yes / No

Signature of Patient or Guardian: _____ Date: _____/_____/_____

Please advise us if your contact information or Medicare details change.

Transfer of Health Information: 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 of a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

kambu
Aboriginal and Torres Strait Islander Corporation for Health