GLEBE
GLEBE FAMILY MEDICAL PRACTICE

NEW PATIENT REGISTRATION FORM – please complete neatly

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr ☐ Other ……

Surname …… **First Name** ……..

Date of Birth ……/……/……

Postal address ……

…… **Suburb** …… **Postcode** ……

Daytime phone …… **Mobile** …… **Work** ……

Email address ……

Emergency contact person …… **Relationship to patient** ……

Mobile number……..**Daytime phone** ……

☐ As Above

Next of kin …….. **Relationship to patient** ……

Mobile number……..**Daytime phone** ……

Ethnicity: ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ ……..

Medicare number …… **or DVA number** ……

Reference number (next to name) …… **Card expiry** ……/……

Pension or Centrelink Health Care Card Number …… **Card expiry** ……/……

Full time student card number …… **Card expiry**……/……..

To whom should the account be addressed if the patient is a child:

Name …….. **DOB** ……/……/……

How did you hear about us?

☐ Google ☐ Facebook ☐ Family/friend recommendation ☐ Other ……..

Please hand this page to Reception. Pages 2 and 3 can be given to your doctor.

GLEBE FAMILY
MEDICAL PRACTICE

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Patient Consent
For Practice Communications

Please read this carefully prior to signing

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

This general practice is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS and email.

In keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please ask reception for a copy of our privacy policy or privacy statement for more information generally on the management of personal information (including health information) by this general practice.

In addition to other communications we may send you from time to time, we may send you the following types of communications:

1. ***SMS appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
2. ***Emailed clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
3. ***SMS clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*
4. ***Emailed health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications below. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications. To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use and disclose my personal information (including any health information) as set out in this form.

I wish to receive health awareness communications (as described above) and I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receipt of such health awareness communications. ☐

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number and email address. I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: _____

Parent/Guardian Name (if Patient is under 16) _____

Signature: _____ Date: _____

MEDICAL INFORMATION – double sided

PATIENT NAME: …… **DOB** ……/……/……

ALLERGIES ☐ **Nil known**

ALLERGY/INTOLERANCES	REACTION	SEVERITY

PLEASE TICK ANY RELEVANT PAST MEDICAL / SURGICAL HISTORY

☐ Heart Disease
☐ High Blood Pressure
☐ High cholesterol
☐ Diabetes
☐ Cancer
☐ Migraine
☐ Stroke
☐ Blood clots
☐ Asthma
☐ Stomach or duodenal ulcer
☐ Epilepsy
☐ Depression / Anxiety

Other illness/surgery – please give details ……

Please list current medications, including vitamins and mineral supplements

NAME	DOSE

NAME	DOSE

IMMUNISATIONS

☐ Pneumococcal (pneumonia) ☐ Influenza ☐ Tetanus ☐ Childhood vaccines up to date

☐ Other (please specify) ……

……

MEDICAL INFORMATION – double sided

PATIENT NAME: …… **DOB** ……/……/……

FAMILY HISTORY

	QUESTION	YES	NO
1.	**Have any of your close relatives had heart disease before 60 years of age?** *Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery.*		
2.	**Have any of your close relatives had diabetes?** *Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes.*		
3.	**Do you have any close relatives who had melanoma?**		
4.	**Have any of your close relatives had bowel cancer before 55 years of age?**		
5.	**Do you have more than one relative on the same side of the family who had bowel cancer at any age?** *Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.*		
6.	**Have any of your close male relatives had prostate cancer before 60 years of age?**		
7.	**Have any of your close female relatives had ovarian cancer?**		
8.	**Have any of your close relatives had breast cancer before 50 years of age?**		
9.	**Do you have more than one relative on the same side of your family who has had breast cancer at any age?** *Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.**		
10.	**Is there a history of mood disorder in your immediate family?**		

If there is a family history of cancer, please specify what kind: ……..

LIFESTYLE HEALTH HISTORY (specify approximate month/year)

Smoking history:-

☐ Never smoked
☐ Former smoker, quit date ……/……..
☐ Current smoker ……../day
Number of years smoking ……..

Alcohol:-

Do you drink alcohol? ☐ yes ☐ no
Drinks per day …….
Drinks per week …….

WOMEN'S HEALTH Last cervical screening test date ……/……Last mammogram date……/……

MEN'S HEALTH Last prostate check (if aged over 40) …….

INFANT PROFILE

Please list any problems during pregnancy ……..
When was the baby born? ☐ Full Term ☐ Premature – how many weeks? ……
Mode of delivery ☐ Normal ☐ Caesarean ☐ Forceps ☐ Vacuum extraction
Please list any health problems for the baby after birth ……
Feeding: ☐ Bottle ☐ Breast fed
Are there any smokers in the household? ☐ yes ☐ no