Patient Registration Form

Previous GP &
phone no (optional):

Title

First Name **Family Name**

Preferred Name

Address

Post code

Phone(H) **Mob** **Work**

Email

I DO NOT want to receive the Practice Newsletter ☐

Date of Birth

I consent to GIMG sending SMS reminders ☑

Mobile No of child (if available) where the child is the patient:

Next of Kin: **Ph(H)** **(M)**

Relationship to Patient:

Emergency Contact: **Ph(H)** **(M)**

Relationship to Patient:

Medicare Card Number: **Ref. No** **Expiry Date:**

Are you receiving a ☐ **Pension** ☐ **Department of Veterans Affairs** ☐ **Health Care Card**

Card Number: **Expiry Date:**

Who is responsible for the account?

DOB of payer if not the patient:

Are there other immediate family members who attend this clinic? If so, who?

Are you of Aboriginal or Torres Strait Islander origin? Yes **Are you Australian?** Yes

Country of Birth:

How did you hear about Glen Iris Medical Group?

☐ **Family/Friend** ☐ **Saw the sign** ☐ **Yellow Pages** ☐ **Web/Internet**

Other:

Please Turn Over & Complete Page 2

Medical History

First Name **Family Name** **DOB**

Current Medications

Name of Medication	Dose

Have you ever had surgery? Please state type of surgery and approximate year.

Type of Surgery	Approximate year

Any other significant medical history the doctor should be made aware of?

Do you have any allergies?

How do they affect you?

Do you receive treatment for your allergies?

Do you smoke? If so how many per day?

Do you drink alcohol? Daily ☐ Weekly ☐ Monthly ☐ Approximate number of drinks?

Do you live Alone ☐ with Family ☐ Friends ☐ Are you married/have a partner?

Do you have children? How many?

What is your occupation?

In keeping with the Privacy act of 2001, we require your written consent as follows:

Our Practice respects your right to privacy. We realize that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information may be disclosed.

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and contact numbers will be used for the purpose of addressing mail to you, utilizing our recall system and sms reminders.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgement, that it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimized wherever possible.
3. We may also use parts of your de identified health information for research purposes, in study groups or at seminars as this may provide a benefit to other patients.
4. Your medical history and any other material relevant to your treatment will be kept here. You may request copies of our records of your treatment, or seek an explanation from the doctor.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can be assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior consent. A copy of our Privacy Policy is available at Reception.

Please sign this form as confirmation that you have red and understood our privacy policy, and consent to the use of your health information in this way.

Print Full Name:

Patient/Parent/Guardian/Signature: Date: