NEW PATIENT REGISTER

Title:_____ Surname:_____ First Name:_____

Middle Name:_____ Preferred Name:_____ Date of Birth:_____

Gender at Birth: Male/Female/Other_____ Identified Gender if different: _____

Residential Address: _____

_____Suburb: _____ P/Code: _____

Postal Address: _____

_____Suburb: _____ P/Code: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Email Address (personal):_____ @ _____

Do you identify as Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Both? ☐

If Aboriginal or Torres Strait Islander are you registered for CTG (Closing the Gap)? Yes ☐ No ☐

Do you identify from a culturally diverse and/ or non-English speaking background? Yes ☐ No ☐

IF Yes, Where_____

How did you hear about GPs on Curzon? (Please tick): Word of mouth ☐ Google ☐ Facebook ☐ Other ☐

Next of Kin (full name):_____

Address: _____ Suburb: _____

Relationship: _____ Phone: _____

Emergency Contact (full name):_____

Address:_____ Suburb: _____

Relationship: _____ Phone:_____

Reminder Systems:

GPs on Curzon provides our patients with preventive health reminders e.g. immunisations, cervical screening tests and skin checks etc. We can provide these reminders via SMS, email or post. These reminders may remind you of future appointments and allow you to confirm your appointment. They may also notify you about your clinical care at the practice, such as returned pathology results or clinical messages from the medical practitioner. The practice will also send clinical reminders, reminding you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations, specialist letters etc.

If you wish to opt-out of the reminder system, please let reception staff know.

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

My preferred method of contact for all communications is:

Phone ☐ Letter ☐ SMS ☐ Hotdoc App ☐ Email ☐ Telehealth ☐

Please present this form, your Medicare card, any concession card and a form of photo ID to reception or Email back to info@curzonmedical.com.au.

Please Turn Over

OFFICE USE ONLY

- ☐ Data entered into Best Practice
- ☐ Medicare/Concession Card/Photo ID sighted by _____
- ☐ PRODA check performed by _____

CONSENT FORM- GENERAL COLLECTION AND USE OF PERSONAL INFORMATION

GPs on Curzon has produced a Privacy Policy that outlines how we collect and use your personal information generally, specifically your personal medical information, and how you can access this information.

Our practice adheres to Australian Privacy Principles and to the 'RACGP Handbook for the Management of Health Information'.

Your personal medical information may be collected, used and disclosed for the following reasons.

- For use by Medical practitioners in this practice when consulting with you.
- For communicating relevant information with other treating doctors, specialists or allied health professionals, to help achieve better health outcomes for you.
- For follow-up, reminder and recall notices.
- For accounting, Medicare or Insurance purposes.
- Quality improvement activities such as accreditation.
- As required by law.
- For employment, Workcover, Rehabilitation purposes where you have attended for that purpose.
- De-identified database searches for Public Health Planning.

This consent form enables us to collect and use your information to provide comprehensive, coordinated and continuing whole person medical care.

We will require a separate specific signed authority from you to release medical information, or a copy of our records, about you to insurance companies, lawyers or another Medical Practice, unless we are required by law to release this information.

The people that have access to your medical information are:-

- The doctors at "GPs on Curzon".
- The nurses at "GPs on Curzon".
- The senior Administrative staff at 'GPs on Curzon".

Other people including the administration staff, have access to your general, demographic and financial information, and may be exposed at various times to some medical information about you in the general course of looking after your health outcomes.

We will at no time divulge any information except in the above scenarios. Any breaches of this policy will be considered serious misconduct.

If you have any questions in relation to this consent form or our privacy policy, please ask our practice manager or the Doctor that you are seeing.

Access to the personal information held by us, about you, can be requested of the practice manager, or to the treating practitioner.

I consent to the collection and use of my information as described above and in the privacy policy:

Patient Name: .....

Signature of patient/ person responsible* .....

Print Full Name (if different to patient) ..... Date: .....

*A "person responsible" means a person defined as a "person responsible" under the Privacy Act 1988 including the patient's partner, family member, carer, guardian, close friend, and a person exercising power under an enduring power of attorney.

Complete and give to the nurses

Patient Name:_____ DOB:_____

Do you have any allergies? Yes ☐ No ☐ If yes, please give more details.

_____

_____

Do you smoke: Yes ☐ No ☐ Ex-Smoker ☐ _____ How many per day

What year did you start? _____ What year did you stop? _____

Do you drink alcohol? No ☐ Yes ☐ how many days per week _____

How many standard drinks on those days? ____

Are you an Elite sportsperson? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐ Are you Pregnant? Yes ☐ No ☐

What is your Occupation? _____

Marital Status – Single ☐ Married ☐ Divorced ☐ De facto ☐ Separated ☐ Widowed ☐

What type of accommodation do you live in? Own home ☐ Hostel ☐ Nursing Home ☐ Rental ☐

Do you feel safe at home? Yes ☐ No ☐

Yes Do you have a carer? ☐ No ☐ Are you a designated carer for someone else? Yes ☐ No ☐

Do you have a regular pharmacy? If so, Please specify:_____

Please provide details of any community services you use. E.g. Blue Care, Meals on Wheels, Home Care, etc.

_____

_____

Do you require a Translator or Relay Service? Yes ☐ No ☐

Complete and give to the Doctor

Patient Name:_____ D.O.B_____

Do you have a history of: (Please tick)

- ☐ Asthma or Emphysema
- ☐ Diabetes or high blood sugars
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Stroke/ TIA
- ☐ Thyroid problems
- ☐ Disability
- ☐ Epilepsy/Seizure
- ☐ Cancer
- ☐ Depression/ Anxiety/ Mental Illness
- ☐ Heart disease/ Heart attack
- ☐ Kidney problems
- ☐ Osteoporosis/ Fracture
- ☐ Chronic Pain
- ☐ Other_____

Have you had any operations in the past and when (if possible)?

_____

_____

_____

Do you take any regular medications? – include dosage if possible and any medications bought over the counter without prescription including vitamins and supplements.

_____

_____

Does anyone in your family have a history of:

- ☐ Diabetes or high blood sugars
- ☐ Cancer
- ☐ Stroke/ TIA
- ☐ High blood pressure
- ☐ Heart disease/ Heart attack
- ☐ Depression/ Anxiety/ Mental Illness

Females - When was your last

- Skin Cancer Check? _____
- Bowel Cancer Screen? _____
- Mammogram? _____ Where?_____
- Cervical Screening Test? _____

Males – When was your last

- Skin Cancer check? _____
- Overall health check? _____
- Bowel Cancer Screen? _____
