Summit Medical Group Patient Registration & Privacy Form

Please fill out all details in BLOCK CAPITALS

Personal Details

Title: ☐Mr ☐Mrs ☐Ms ☐Master ☐Miss ☐Dr ☐Other _____

Surname:

First Name:

Date of Birth: / / in DD/MM/YYYY format 14/07/2008

Sex: ☐Male ☐Female

Ethnicity: ☐Aboriginal ☐Torres Strait Islander ☐Aboriginal & Torres Strait Islander ☐Neither

Address:

Suburb: Postcode

Phone: Home ( ) Work ( )

Mobile

Email:

Medicare / Pension / Insurance Details

Medicare No: Ref No Exp Date /

Please tick: ☐Pension or ☐Health Care Card No: Exp Date / /

Veteran's Affairs No: Exp Date / /

OSHC Worldcare: Exp Date / /

Emergency Contact

Name: _____ Relationship: _____

Phone: H ( ) W ( ) M

Allergies

Do you have allergies to any **medications**? ☐Yes ☐No. If so please list _____

Social History

Occupation:

Do you smoke? ☐Yes ☐No. How many per Day? _____. Previous Smoker? ☐Yes ☐No. Quit date?_____ _____

Do you drink Alcohol? ☐Yes ☐No. How many days per week do you drink? _____. On each of those days how many drinks? _____

PLEASE TURN OVER .....

Medical History

Have you ever been admitted to hospital? ☐Yes ☐No. If so, for what reason & when?_____

Have you been diagnosed by a doctor as having any of the following medical problems? (Tick for Yes):

☐Heart Attack ☐Stroke ☐Asthma ☐Emphysema ☐Thyroid ☐High Blood Pressure
☐Diabetes ☐Heartburn ☐Stomach Ulcer ☐Migraines ☐Depression ☐Anxiety
☐Arthritis ☐Skin Cancer ☐Breast Cancer ☐Bowel Cancer

Have you been diagnosed with any other medical problems? Please list with approximate dates

_____

_____

_____

For women only: when was your last Pap Smear? _____

Do you take any regular medications? Please List

Medication Name	Strength	Dosage	For What Condition

Family History

Are your parents still alive? Mother ☐Yes ☐No. Father ☐Yes ☐No.
If your parents are deceased state at what age and cause of death.

Mother _____ Father _____

Is there any significant medical problems in your family e.g. Diabetes, Heart Disease, Breast or Bowel or any other type of Cancer? If so please detail. _____

Other Details

Who was your previous GP? Name

Clinic Name

Phone Number ( )

If you wish for us to request a copy of your medical records from your previous GP please ask the receptionist for a separate form to fill out and sign. This will be faxed to your previous GP.

How did you find out about us? ☐Friend / Relative ☐Other Health Professional ☐Yellow Pages
☐Internet ☐Driving / Walking Past Other _____

Privacy Agreement and Patient Consent

I understand that Summit Medical Group complies with the Privacy Act (1988) and as part of its privacy policy, it is committed to protecting the privacy of individuals and their personal information. I consent to Summit Medical Group collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow for quality medical care; inclusion in a recall register to be advised of follow up visits, inclusion in national / state reminder systems / registers (e.g. pap smear registers). I understand that I may withdraw my consent for Summit Medical Group to use and disclose my personal information (except where legal obligations must be met.)

Signature _____ Date _____

For administration use only

☐Height _____ cm ☐Weight _____ kg. ☐Check Medicare ☐ATSI recorded

Receptionist initials: _____ GP initials: _____