Summit Medical Group Patient Registration & Privacy Form

Personal Details

Title:

Surname:

First Name:

Date of Birth:

Sex:

Ethnicity:

Address: Unit / Flat No Street No

Street Name

Suburb Postcode

Phone: Home

Mobile

Email:

Medicare / Pension / Insurance Details

Medicare No: Ref No Exp Date

Pension Card No: Exp Date

Health Care Card No: Exp Date

Veteran's Affairs No: Exp Date

OSHC Worldcare No: Exp Date

Emergency Contact

Name: Relationship:

Phone: Home

Mobile

Next of Kin

Is your Emergency Contact the same as your Next of Kin? _ If NO, Give details of Next of Kin below.

Name: Relationship:

Phone: Home

Mobile

Previous GP

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 sen t to your previous GP to request a copy of your records.

How did you find out about us?

PLEASE FILL OUT THE NEXT PAGE AS WELL .....

Allergies

Do you have allergies to any **medications**? If YES please list

Social History

What is your Occupation:

Do you smoke? If YES How many per Day? Previous Smoker? Quit date?

Do you drink Alcohol? If YES How many days per week do you drink? On each of those days how many drinks?

What is your Marital Status? Who do you live with?

Medical History

Have you recently been admitted to hospital? If so, date? and for what reason?

Have you been diagnosed as having any of the following medical problems? (Tick for YES)

Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Asthma ☐

Bowel Cancer ☐ Depression ☐ Breast Cancer ☐

Have you been diagnosed with any other medical problems? Please list with approximate dates when they were diagnosed.

What is your: Height (cm) Weight (Kg)

For women only: when was your last Cervical Screening Test / Pap Smear?

Do you take any regular medications? Please List.

Medication	Strength	Dosage	For What Condition
—	—	—	—
—	—	—	—
—	—	—	—
—	—	—	—
—	—	—	—

Family History

Is your Mother still alive? If NO Cause of Death and age at Death

Mother's significant medical problems (Tick for YES):

Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Asthma ☐

Bowel Cancer ☐ Depression ☐ Breast Cancer ☐

Is your Father still alive? If NO Cause of Death and age at Death

Father's significant medical problems (Tick for YES):

Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Asthma ☐

Bowel Cancer ☐ Depression ☐ Breast Cancer ☐

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 (If filling electronically, type your name) Date

For administration use only

☐Height ☐Weight ☐Check Medicare ☐ATSI recorded

Receptionist initials: __ GP initials: __