NEW PATIENT REGISTRATION FORM

aberfoyle park FAMILY PRACTICE

PLEASE HAND PAGES 1 & 2 BACK TO RECEPTION STAFF ONCE COMPLETED & TAKE PAGE 3 TO THE DOCTOR

Title (please tick ✓)	Mr ☐ Mrs ☐ Miss ☐ Master ☐ Ms ☐ Dr ☐ Other	
Gender	Male ☐ Female ☐ Non-Binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity ☐	
Given Name (as per Medicare Card)		**Preferred Name**
Surname		
Date of Birth		**Country of Birth**
Medicare Card No. (10 numbers)	☐☐☐☐ ☐☐☐☐☐ ☐ **Ref No.** ☐ **Expiry Date:** __ __ / __ __	

Concession Cards

Pension ☐ **Healthcare Card** ☐ **DVA Number** ☐ **No Concessions** ☐

Number on Card _____ Expiry Date: __ __ / __ __ / _ _

Residential Address		
Postal Address (if different from above)		
Mobile No	**Home No**	**Work No**
Email		
Patient's Occupation		
Next of Kin	Full Name _____ PH _____ Relationship to you (i.e. mother) _____	
Emergency Contact (Ideally not the same as your next of kin)	Full Name _____ PH _____ Relationship to you _____	

Knowing your cultural background can help us provide health care that meets your individual needs
Are you of Aboriginal or Torres Strait Islander Origin?

No ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander** ☐

Other cultural background (e.g. Mediterranean, Asian, African) _____

DO YOU PROVIDE PERMISSION FOR THE PRACTICE TO LEAVE A BRIEF VOICE MESSAGE ON YOUR PHONE **Yes** ☐ **No** ☐

Name _____ **Signature** _____ **Date** _____
(Patient/Guardian)

NEW PATIENT REGISTRATION FORM

aberfoyle park FAMILY PRACTICE

PATIENT PRIVACY

Aberfoyle Park Family Practice is committed to providing our patients with quality health care, and we are committed to protecting your privacy in accordance with the National Privacy Principles (NPP) this extends not only to our Doctors but all Staff who have all signed a confidentiality statement.
All information we collect is placed in your patient file and is only accessed when necessary for your care. We may need to disclose your personal information to others involved in your health care, including specialists, allied health and diagnostic providers. This information may include referrals, reports and results.
You may decline to have your health information used in all or some of the ways outlined above but this may influence our ability to manage your health care to provide the best outcome for you.
For further information on patient privacy, please ask for a copy of our practice privacy policy.

Please note any email correspondence is not a secure method of forwarding confirmation information.

PATIENT CONSENTS

The current Privacy laws require that we obtain your consent to send reminders regarding your health. Do you consent to us sending the following types of communications to you from time to time via SMS? Please note we do not send Junk Mail.

APPOINTMENT REMINDERS – notifications sent to the mobile number on your record advising your upcoming appointment, this is sent 24 hours in advance to your appointment time. **Yes** □ **No** □

CLINICAL REMINDERS – notifications to you reminding you to contact the practice to book an appointment for regular clinical check-ups, results and immunisations due etc. **Yes** □ **No** □

CLINICAL COMMUNICATIONS – communications to you about your clinical care at the practice such as returned pathology results or clinical messages from your Doctor. **Yes** □ **No** □

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 clinical opening hours, and information about health care services provided by this general practice. **Yes** □ **No** □

If you do not consent to these reminders, a note will be stored in your health record. It is important we have your current mobile phone, please notify us of any changes.

APPOINTMENT CANCELLATION AND 'NO SHOW' POLICY

We request that patients provide a minimum of 2 hours' notice if they cannot attend or need to reschedule their appointment.

Whilst we understand that occasionally a patient will be unable to make a scheduled appointment due to unforeseen circumstances should you fail to notify us within the requested time frame, ie 2 hours' notice or fail to attend on three or more occasions you may incur a non-attendance fee of $40.00 this is at the discretion of the Doctor. This fee is non-claimable from Medicare.

I have read and understand the cancellation policy of this practice and understand that if I cancel without adequate notice I may incur a non-attendance fee unless otherwise agreed.

Patient Signature _____ Date _____

*PLEASE TAKE THIS COMPLETED **MEDICAL HISTORY** FORM INTO THE DOCTOR WITH YOU*

PATIENT NAME _____ **DOB** _____

ALLERGIES Do you have any allergies or are you sensitive to any drugs, foods or dressings? If YES, state Type and Reaction Below

CURRENT / PAST MEDICAL HISTORY AND ANY OPERATIONS please indicate date of onset or operation if known

CURRENT MEDICATIONS please include any over the counter medications; vitamins and minerals

SIGNIFICANT FAMILY HISTORY NIL KNOWN ☐

MOTHER Depression ☐ Asthma ☐ Cancer (please state type) _____ Other _____

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

FATHER Depression ☐ Asthma ☐ Cancer (please state type) _____ Other _____

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

DO YOU HAVE A CARER? Yes ☐ No ☐ **ARE YOU A CARER?** Yes ☐ No ☐

ALCOHOL INTAKE Non drinker ☐ Drinker: Current Intake days _____ per week; Standard no. _____ drinks per day

SMOKING Never smoked ☐ Ex- smoker ☐ Smoker ☐ if yes, how many per day _____

Drug use: No ☐ Yes ☐ If yes, (type and frequency) _____

IMMUNISATION HISTORY

Influenza Year _____ Not Known ☐ Never ☐ COVID-19 Year _____ Not Known ☐ Never ☐

Childhood Immunisations are they up to date? Yes ☐ No ☐

WOMEN Are you breast feeding? Yes ☐ No ☐ Date of last CST (pap smear) _____

Date of last Mammogram (over 50) _____

MEN Have you ever had a Prostate Check (over 50) Yes ☐ No ☐

Our Practice supports the "My Health Record" **Are you registered:** Yes ☐ No ☐