Colchester Medical Centres

310 Colchester Road, Bayswater North Vic 3153

www.yourfamilydoctor.com.au

New patient registration form: Please present completed forms to reception

Contact Information

Family name:		
Given name:	Preferred name:	
Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss	Date of birth:	
Sex at Birth:	Pronouns ☐ he/him ☐ she/her ☐ they/them	
Gender: ☐ Male ☐ Female ☐ Indeterminate ☐ Non-specific		
Home Address: Suburb:	Postcode:	
Postal Address: ☐ Same as above		
Mobile Phone:	Home Phone:	
Email Address:		

Health care Identifiers

Medicare Card No:	Ref:	Expiry:
DVA Card number:	Colour: ☐ Gold ☐ Orange ☐ White	
Pension/Health care card number:		Expiry:

Cultural Identity

To assist with health initiatives - are you of Aboriginal and /or Torres Strait islander descent?

☐ Yes- Aboriginal ☐ Yes- Torres Strait Islander ☐ Yes- Both Aboriginal & Torres Strait Islander ☐ Neither

Country of Birth:	Ethnic Background:
Languages spoken:	
Do you require an interpreter service? ☐ Yes ☐ No	

Patient MyHealthRecord Status

Do you have MHR (My health record)? ☐ Yes ☐ No ☐ Unsure

Patient Advanced Care Directive Status

Do you have an Advanced Care Directive? ☐ Yes ☐ No ☐ Unsure

Next of Kin / POA

Name:	Relationship to Patient:
Mobile Phone:	Home phone:
Email:	Work phone:

Other Emergency Contact (different to above)

Name:	Relationship to Patient:
Mobile Phone:	Home phone:

Please complete all 3 pages

Information & Privacy Patient Consent:

Both Knoxfield and Colchester medical centres collect information from you for the purpose of providing quality health care. We require you to provide us with your personal details and a medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.
Our practice sends reminder via post, email, telephone or SMS for appointments and health reviews.

We may use the information you provide in the following ways:

- Administration purposes
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice i.e. through referrals, medical tests, reports or results.
- Disclosure to other doctors, medical students, allied health workers and nurses who may work within both practice settings and Accreditation surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosures for research and quality assurance activates to improve individual and community health care and practice management. This information will be de-identified.
- Providing our patients with preventative care and early case detection reminders (e.g. immunisations, annual health checks, bone bus initiative, skin checks and pap smears).
- For Australian Immunisation Register, Cervical Screening Register, etc. (these may contact you independently).
- For legal purposes e.g. court orders or subpoenas as required by law.
- For infectious disease notification as required by law.
- During the course of providing medical services through My Health Record Shared Health Summaries or Event Summaries.

By signing this document below, I agree to the following:

- I have read the information above and understand the reasons why my information may be collected. I am also aware that both clinics have a privacy policy on handling sensitive patient information.
- I understand I am not obliged to provide any information requested of me, but that my failure to do so may compromise the quality of care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access may legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purposes other than set out above, my further consent must be obtained.
- I agree to the fee policy set out by the clinic.

By completing and providing a signature below, I consent to the handling on my information by both Knoxfield and Colchester Medical Centres for the purposes set.

If there are any concerns, please bring them up with your doctor/reception staff.

Will you be a regular patient of our clinic and consent to registration with My Medicare?

☐ **Yes** ☐ **No**

Patient Name

Your name (if not patient) Relationship to the patient

Signature Date

Medical History Information:

Do you have any allergies or are you sensitive to drugs or dressings?

Please include reaction

☐ No ☐ Yes _____

Do you Drink Alcohol?

☐ No ☐ Yes _____ Per Day / Month / Year

Do you Smoke?

☐ No ☐ Yes _____ Per Day

Do you or have you had a history of the following? (please tick any that apply)

☐ Operations _____ ☐ Asthma _____

☐ Diabetes _____ ☐ High/Low blood pressure _____

☐ Chronic Illness _____ ☐ Other _____

Immunisations

Are your immunisations up to date?

☐ Yes ☐ No ☐ Don't know

Children's Immunisations

If completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No ☐ Not applicable

Current Medications

Please list all current medications including over the counter medications, vitamins and minerals:

_____ _____

_____ _____

_____ _____

Is there anything else you would like your doctor to know?

_____

_____

Past Medical Records/History

Would you like to transfer your past medical records/history to Knoxfield/Colchester Med Centre?

☐ No ☐ Yes, **Please see reception**

Please complete all 3 pages