New Patient Registration Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please be aware if you fail to provide or disclose accurate information regarding your medical care or medical history, Wangaratta Medical Centre have the right to refuse accepting you as a new patient at your initial consultation and you will be charged a consultation fee as per our patient fees.

Contact Information	
Gender:	
Title:	
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	

Emergency Contact Details (you will not be accepted as a New Patient without completion)	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Next of Kin (you will not be accepted as a New Patient without completion)	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ___/_____

Cultural Identity

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

wangaratta medical centre

New Patient Registration Form

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes - Please elaborate _____

To assist with any communication impairment, do you require the assistance of a translator or interpreter service: (NRS/TIS) ☐ No *If yes, do you require an interpreter service?* ☐ No ☐ Yes

Country of Birth:_____ Ethnicity:_____

Your Health Information

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

☐ No

☐ Yes – provide details: _____

CURRENT MEDICATIONS – Please list all your current medications, including complementary and over-the-counter medicines (e.g. homeopathic medicines such as vitamins and minerals etc.)

Please note: our doctors are unable to prescribe - Opioids, Morphine, Endone, Oxycodone, Targin, Palexia, pain patches, Methadone, Diazepam, Oxazepam, Temazepam, Alprazolam, Seroquel/Quetiapine, Olanzapine, Zolpidem, Zopiclone or any medication considered a drug of addiction. If you have previously taken any of these medications, please be aware that the treating doctor still has the right to refuse further prescribing of these medications and you may be refused to book further appointments at this clinic if the doctor deems necessary. The consultation will be charged as per our patient fees.

_____

_____

_____

MEDICAL HISTORY - Do you have or have you had a history of the following?

☐ Surgery – provide details: _____

☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness

☐ Other – provide details:

_____

Height: _____ cms **Weight:** _____ kgs

For those 65 years and older: when was the last time you were immunised?

Influenza	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia	Date_____	☐ not sure	☐ never

New Patient Registration Form

Children's immunisations - if completing this form for a child, are their immunisations up to date?

☐ Yes ☐ No

Females: When did you last have:

Pap smear	Date_____	☐ not sure	☐ never
Breast Check	Date_____	☐ not sure	☐ never

Males: When did you last have:

An overall check-up	Date _____	☐ not sure	☐ never

LIFESTYLE RISK FACTOR INFORMATION

Smoking

☐ No ☐ Ceased – date:_____

☐ Yes - how many _____ day / _____week

Alcohol

☐ No ☐ Yes - how many _____ day / _____ week / _____ month

Recreational Drug Use

☐ No ☐ Yes - type_____ frequency _____

Sun Protection - How often do you use the following to protect yourself from the sun when outdoors?

	Always	Often	Sometimes	Rarely	Never
Protective clothing	☐	☐	☐	☐	☐
Sunscreen creams	☐	☐	☐	☐	☐

Family Health History Information

Have any members of your family have:

☐ Heart Disease ☐ Asthma ☐ Diabetes ☐ Hypertension (high blood pressure) ☐ Mental Illness

☐ Cancer – type:_____

☐ Other significant - provide details:_____

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

Do you consent to have any relevant health reminders sent to you?

☐ Yes – Phone, SMS or Mail (please circle your preference) ☐ No

New Patient Registration Form

If we need to contact you what is your preferred method of contact:

☐ Home phone ☐ SMS ☐ Mobile ☐ Mail ☐ Email - **NO clinical information will be forwarded**

Do you give consent for us to upload your eHealth Record: ☐ Yes ☐ No

Do you give consent for us to submit Medicare Benefits on your behalf to Medicare: ☐ Yes ☐ No

Do you consent to receiving your investigation results via secure SMS: ☐ Yes ☐ No (Opt out at any time)

Do you consent to receiving appointment reminders & messages SMS: ☐ Yes ☐ No (Opt out at any time)

This practice participates in Quality Improvement in conjunction with the Department of Health and as part of this process de-identified health statistics is shared with authorised Departments. Please advise if you do not want to participate.

*****IT IS A POLICY OF THIS PRACTICE THAT PAYMENT IS MADE AT THE TIME OF CONSULTATION**.***

Health Information Collection, Use and Disclosure - Patient Consent Form

Please read this consent form carefully prior to signing.

Wangaratta Medical Centre collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

New Patient Registration Form

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Patient Code of Conduct

Help us make our clinic a safe place for everyone.

Under the Victorian Occupational Health and Safety Act 2004 (the Act), we must provide a safe and healthy work environment for all workers (including employees, contractors and visiting service providers) and the general public (patients & visitors).

The doctors at Wangaratta Medical Centre have a professional responsibility to be familiar with the Good Medical Practice: A Code of Conduct for Doctors in Australia. This code describes what is expected of all doctors and sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community.

New Patient Registration Form

The staff at Wangaratta Medical Centre follow a Code of Conduct where all employees will behave in a courteous and professional manner whilst maintaining the levels of service and care which the practice and our patients expect. In return, Wangaratta Medical Centre requests all patients and visitors to the centre help us to make our clinic a safe place for everyone. We request that all parties treat everyone with respect.

We will not accept or tolerate:

- Swearing at staff or in the presence of staff/other patients
- Shouting or making offensive remarks
- Making verbal or physical threats
- Racism
- Attending when intoxicated with alcohol and/or drugs
- Damaging or stealing property
- Acting in a manner that is likely to cause harassment, alarm, or distress to others in the general practice
- Physical attack, such as pushing, shoving, grabbing, hitting, pinching, scratching, kicking, biting, spitting or any other type of direct unwanted physical contact.
- Aggravated assault, such as attacking with a weapon (knives, guns, clubs) or any other type of weapon (thrown object, furniture etc.)
- Sexual harassment and/or sexual assault

Anyone who carries out the above behaviour/s will be asked to leave and their future attendance at the practice may be discontinued resulting in having to seek health care elsewhere. Please complete the form below if you understand and agree to the following statements:

I, _____ have read the information above in relation to my code of conduct whilst at the clinic and agree to abide by the Patient Code of Conduct conditions.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number.

New Patient Registration Form

I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____Date: ___/___/

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____

Medical Release Authority

Date: _____

Dr/Clinic Name:_____

Dr/Clinic Address:_____

Phone: _____ Fax: _____

Email: _____

Re: Patient _____ D.O.B._____

Patient Medical Release Authority - Any Patient over 16, please sign:
I, hereby authorise the release of my medical records to the Wangaratta Medical Centre.

Patient Name: _____**Signed**: _____**Date**: _____

The above patient has elected to attend this Practice. We would be grateful if you could forward a summary of their past history or any relevant information which may help with the ongoing care of the patient including the following if applicable*:*
Information may be sent via: MD Exchange or CD in XML Format if using Medical Director OR securely via email to: reception@wangmed.com.au
PLEASE NOTE: BEST PRACTICE xml/html IS NOT COMPATIABLE WITH OUR CLINICAL SYSTEM

New Patient Registration Form

	Item & Date Performed		Item & /Date Performed
Health Assessment		GP Mental Health Care Plan or review	
GP Management Plan or review		Diabetes Annual Cycle of Care	
Team Care Arrangements		Medication review DMMR/RMMR	
DVA six month medication review			

Office Use Only

Wangaratta Medical Centre GP Signature of Approval:_____

Approving GP Name: _____ Date: _____