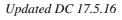


Patient Registration

Only information needed to assist in your health care is collected by the doctors, the nurses and the staff of this practice. Our practice follows the Royal Australian College of General Practitioners guidelines for management of health information in private medical practice and this form complies with those standards. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Mr/Mrs/Ms/Miss/Master Surname:	Given Name/s:					
Preferred Name:						
Date of Birth:///	Gender: Male 🗆 Female 🗆					
Marital Status (circle): Single, Married, Engaged, Div	rorced, de facto, have a partner, widowed, other					
Residential Address:						
Suburb:	Postcode:					
Postal Address:						
Suburb:	Postcode:					
Phone Home: Work:						
Mobile:						
Email:						
Medicare number:	Reference No.:					
Expiry: /						
Pension/Health Care number:	Expiry: /					
DVA number:	Expiry: /					
Type of card: Gold/White - White covers:						
Aboriginal/TSI: Yes / No / Do not wish to disclose	Cultural background					
Emergency contact:	Relationship					
Phone:						
	Relationship					
Phone:						
Other family members attending this practice:						
Preferred language:	Any special needs:					
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Health for Life



Informed Consent

Mannum Medical Centre requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes and sign where indicated below.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs. Please place a tick in the following boxes if you give consent for this information to be used by the Practice in the following ways:

Print name of Patient: Dat	e of Birth		
Signature of Patient:			
I give my permission for my personal health information to be used for adm purposes to assist in the running of Mannum Medical Centre, including disclosur in my healthcare, such as treating doctors and specialists within and outside th This may occur through referral to other Doctors, or for medical tests and in the returned to my doctor following referrals.	re to others involved is Medical Practice. Noted on Alerts		
I give my consent for disclosure for research and quality assurance activities individual, community health care and Practice management. This may occur we incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used improvement projects. De-identifiable patient information cannot be traced back to the individ	for quality		
I give my consent to the presence of a third party to be present during my consultation. This may include a Practice Nurse or medical student.			
 I give my consent to be part of the Practice's recall and reminder systems. I give my consent for the Mannum Medical Centre to contact me via mobile appointment reminders ONLY. Mobile number: 	advise Practice Nurse		
I give consent for the people listed below to make enquiries on my behalf Relationship Appointments Name:	Clinical Information		
Note: all children above the age of 14 can request that NO information be gi consent.	iven out without their written		
I understand by ticking the relevant boxes above that the Practice is authorised personal health information and I am free to withdraw my consent at any one t			
Full Name/s of children under 14 also covered by this consent:	Date of Birth		
 Date:	at turn		

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Website: www.mannummedical.com.au

Medical History

Surname:		Given Name/s:					
Date of Birth:	/	/		Gender:	Male \Box	Female 🗆	
Do you have a	ny allergies t	o medicin	es or any	thing else?	No 🗆	Yes □	
Item			Rea	action			
			:				
			:				
			:				
Current Occupa	ation:						
Social							
Alcohol	Never □ Da yes □ yes □	ily □ Week no □ no □	ly □ Mon Freque previou previou	thly □ per d ency with which o never □ less that usly □ duration: usly □	ay/week/month 6 or more standard an monthly mon type: type:	en did you stop when did you stop d drinks are consumed on one occa thly □ weekly □ daily or almost da	asion ily 🗆
Father: If no longer livino Mother:	/ Idren? Yes □ parents are st g. What age c	No □ If ye ill living do lid they pas	s how ma they have s away ar	ny? F any specific	M health problem he cause?		
Any other immed							

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