Mannum Medical

PO Box 7
MANNUM
Phone: 08 8569 0222
Facsimile: 08 8569 0220

Website: www.mannummedical.com.au

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, Divorced, 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: _____

Next of kin: _____ Relationship _____

Phone: _____

Other family members attending this practice:

_____

Preferred language: _____ Any special needs: _____

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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: _____ Date of Birth _____

Signature of Patient: _____

☐ I give my permission for my personal health information to be used for administrative purposes to assist in the running of Mannum Medical Centre, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

☐ I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. This may occur when the Practice incorporates patient health records into
de-identifiable patient information to transfer to a third party, normally used for quality improvement projects.
De-identifiable patient information cannot be traced back to the individual.

☐ 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 phone to SMS for appointment reminders ONLY.

Mobile number: _____

☐ I give consent for the people listed below to make enquiries on my behalf

	Relationship	Appointments	Clinical Information
Name: _____		☐	☐
Name: _____		☐	☐

Note: all children above the age of 14 can request that NO information be given out without their written consent.

OFFICE USE ONLY *Tick if done*
Noted on Alerts ☐
NO CONSENT, advise Practice Manager ☐
Noted on Alerts ☐
NO CONSENT, advise Practice Nurse ☐
Checked and updated ☐
Noted on Alerts ☐

I understand by ticking the relevant boxes above that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

Date of Birth

Full Name/s of children under 14 also covered by this consent: _____

_____

Date: _____

PLEASE TURN OVER

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Medical History

Surname: _____ Given Name/s: _____

Date of Birth:_____/____/_____ Gender: Male ☐ Female ☐

Do you have any allergies to medicines or anything else? No ☐ Yes ☐

Item	Reaction
	:
	:
	:

Current Occupation: _____

Social

- Cigarette Smoker ☐ non-smoker ☐ ex-smoker ☐ when did you stop _____
- Alcohol Never ☐ Daily ☐ Weekly ☐ Monthly ☐ per day/week/month ____ when did you stop _____

Frequency with which 6 or more standard drinks are consumed on one occasion
never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily ☐

- Exercise yes ☐ no ☐ previously ☐ type:_____
  duration: _____
- Illicit drugs yes ☐ no ☐ previously ☐ type: _____

Frequency: _____

Aboriginal/TSI: Yes / No / Do not wish to disclose Cultural background _____

Family History

Do you have children? Yes ☐ No ☐ If yes how many? F _____ M _____
Parents: If your parents are still living do they have any specific health problems?
Mother: _____
Father: _____

If no longer living. What age did they pass away and what was the cause?
Mother: _____
Father: _____

Any other immediate family members with significant health problems?

_____