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/Other_____

Surname: _____ Given Name/s: _____
Preferred Name: _____

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

U/18 Is there a 'parenting order' or any other 'court order' in place ☐ Yes ☐ No *If yes a copy should be placed on the patients file.

Marital Status: 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/HCC/DVA: _____Expiry: ____/____/____

Type of card: Gold/White - White covers: _____

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

Is English your first language? ☐ Yes ☐ No if not, do you require an interpreter? ☐ Yes ☐ No Language_____

Next of kin: _____ Relationship _____

Phone: _____

Emergency contact: _____ Relationship _____

Phone: _____

Other family members attending this practice: _____

Any special needs: _____

Signature: _____ **Date:** _____

Consent for use of information.
I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of my health care planning and management of my health.
I confirm there is no other information that I am aware of that would influence the medical treatment/advice to be provided.

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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 and 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:

Name of Patient: _____ Date of Birth _____

OFFICE USE ONLY
Tick if done

☐ 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.

NO CONSENT, advise Practice Manager ☐

Noted on Alerts ☐

☐ 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.

NO CONSENT, advise Practice Nurse ☐

☐ I give my consent to be part of the reminder system (prevention i.e. skin check)

Checked and updated ☐

☐ I give my consent for the Mannum Medical Centre to contact me via SMS.

Mobile number: _____

Noted on Alerts ☐

☐ 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.

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: _____

_____

Signature: _____ **Date:** _____

PLEASE TURN OVER

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Medical History

Surname: _____ Given Name/s: _____

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

Do you have any allergies or are sensitive to medicines or dressings? No ☐ Yes ☐

Item	Reaction :
	:
	:

Family/Social/Past History

Current Occupation: _____

Do you have children? Yes ☐ No ☐ If yes how many? F _____ M _____

Family History

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?

_____

Social History

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

Smoking

- Cigarette Smoker ☐ non-smoker ☐ ex-smoker ☐ when did you stop _____
- Illicit drugs yes ☐ no ☐ previously ☐ type: _____

Alcohol

- Frequency of consumption of drinks containing alcohol
  never ☐ 2-3 days week ☐ 4+ days week ☐ Monthly or less ☐ 2-4 days month ☐
- On days when drinking number of standard drinks consumed
  1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+ ☐
- Frequency with which 6 or more standard drinks are consumed on one occasion
  never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily ☐

Do you have an Advanced Health Directive for end of life care? ☐ Yes ☐ No *For more information talk to your GP*