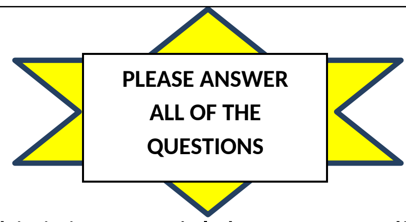
Inglewood Medical Centre
New Patient Registration Form



We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

First Name:	Middle Name:	Surname:
Preferred Name:	Date of Birth:	Male / Female / Other

Medicare Number:	Ref No.	Expiry Date
DVA Gold/White Card No:		Expiry Date
Pension/Health Care Card No:		Expiry Date

Do you identify yourself as: ☐ Aboriginal ☐ Torres Straight Islander ☐ Both ☐ Neither

Residential Address:

Postal Address:

Mobile No:	Work Phone:	Home Phone:

Email:	**Occupation:**

Next of Kin - Name: Relationship to patient:

Address: Phone:

Marital Status (Please circle): Married/De Facto Widowed Divorced Single

Country of Birth: Year of Arrival in Australia:

Any known allergies? Please list & include nature of reaction (eg rash, hives)

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

Do you require an interpreter service? Yes / No

Smoking:

☐ Never smoked ☐ Smoker – how many/day: ______ ☐ Ex-smoker – year stopped:________

Alcohol:

*How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 + times a week

*How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 10 or more

*How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Living arrangements: (eg Lives alone, with family members, with friends)

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Own home/Rental/Other:………………………………………………………………………………………………………

Do you suffer from, or are you affected by any of the following?

Diabetes: Y / N Asthma: Y / N Hypertension: Y / N Other: Please list……….

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Past Operations:……….

Major Illness / Hospitalisations:………………………………………………………………………………………..

Females: When did you last have:

Cervical Screen: Not sure Never Date:…….…….

Breast Check: Not Sure Never Date:…….………

Mammogram: Not Sure Never Date:…………….

Family History: Please list any members of your family who have been diagnosed or suffer from:

Diabetes: ………………………………………………. Asthma:…………………………………………………….

Hypertension:……………………………………………. Heart Disease:………………………………………………

Stroke: …………………………………………………… Depression: …………………………………………….

Cancer (please state type) ……………………………………………………………………………………………

Mother – alive? Yes / No If No, Age of Death: …………. Cause of Death: ……………………..
Father – alive? Yes / No If No, Age of Death: …………. Cause of Death: ……………………..
Do you have Children? Yes / No If Yes, please provide details : ……………………………………….
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Childrens immunisations:
If completing for a child, are their immunisations up to date? Y / N
Immunisations:
Up to date record of your current immunisations status is valuable medical information.
Please list all recent vaccinations you have had: …………………………………………………….
Reminder Systems:
Our practice provides our patients with preventative care and early case detection reminders, eg.
Immunisation; annual health checks and pap smears.
Do you wish to have any relevant health reminders? Yes / No

Health information Collection and Use Consent Form

As a patient of Inglewood Medical Centre we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat, and be proactive in your health care needs.

We aim to protect the privacy of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways.

- Administrative purposes in running our medical practice
- Billing purposes, including complain with Medicare and Health Insurance Commission requirements.
- Disclosure to other involved in you healthcare including treating doctors and specialist outside this medical practice.
- Disclosure to other doctors in the practice, Locums, Medical Students attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management.
- To comply with any legislative or regulatory requirements eg. Notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

Please read this consent form carefully, and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

- ☐ I have read the information and understand the reasons why my information must be collected.
- ☐ I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- ☐ I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- ☐ I consent to the handling of my information by the practice set out above, subject to any limitations on access or disclosure of which I notify this practice.

Patient Name: ________________________________

Signature: ___________________________________

Date: ______________

Thank you