MACG
Medical & Aged Care Group

Patient Registration Form

PERSONAL DETAILS

Title : Mr / Mrs / Ms / Miss / Master

Family Name:…….

Given Name:……. Preferred Name: …… Date of Birth: …… / …… / … … …

Address:…… Postcode .. ……

Postal Address: …… Postcode .. ……

Telephone: .Home: … … … … … …. … …. …. …. Work: … … … …. … … ….. Mobile … … … … … … …….

Occupation …….

Aboriginal/Torres Strait Islander: Yes/No (please circle) Cultural Heritage: e.g. English/Greek/Italian/Sri Lankan/Other …….

Do you wish to identify yourself as belonging to a specific religious group? .....

Do you have any known allergies? Please list ……

EMERGENCY CONTACT / NEXT OF KIN:

Next of Kin Name: … Relationship to you: … … … … …

Telephone: Home:……..…….. Mobile:…..…… Work…...…….

Emergency Contact Name: … … … … … … … … … … … … … … … … … Relationship to you: … … … … …

Telephone: Home:……..…….. Mobile:…..…… Work…...…….

ACCOUNT DETAILS

MEDICARE No: …. …. …. …. / …. …. …. …. …. / …. Ref No: …. Expiry Date: …. / … … / ……

PENSIONER HEALTH BENEFIT CARD: …… Expiry Date: … … / …… / …….

HEALTH CARE CARD: …….. Expiry Date: … … / …… / ……..

DEPARTMENT OF VETERANS AFFAIRS: …

PRIVACY STATEMENT – Privacy Act (Cwlth) 1988; Privacy Act Amendment 2001; Privacy Act Amendment 2012 outlining the Australian Privacy Principles (APP); Health Records Act (Vic) 2002

In keeping with the above Acts, we require your consent as follows:

Our Practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and contact numbers will be used for the purpose of addressing mail to you, utilising our recall system and SMS reminders.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgment, it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.
3. We may also use parts of your de-identified health information for research purposes, in study groups or at seminars as this may provide a benefit to other patient.
4. Your medical history and any other material relevant to your treatment will be kept here. You may request copies of our records of your treatment, or seek an explanation from the doctor.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.
6. All personal information is held securely, whether in electronic format, in protected information systems or in hard copy format in a secure environment.

You can be assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your consent. A copy of our Privacy Policy is available at reception.

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed : …. …. …. …. …. …. …. …. …. …. …. …. …. …. …. …. …. …. Date: …. …. / …. ….. / . ……...

Title: _____ Full Name: _____ Date of Birth: / /

Family History

Do you have a family history of any of the following? Family member (e.g. Mother, Father, Sister, Brother etc.)

☐ Bowel Cancer		Relative: _____
☐ Breast Cancer		Relative: _____
☐ Prostate Cancer		Relative: _____
☐ Blood Pressure	High / Low	Relative: _____
☐ Cholesterol	High / Low	Relative: _____
☐ Diabetes	Type 1 / Type 2	Relative: _____
☐ Heart Disease	Stroke / Heart Attack	Relative: _____
☐ Asthma		Relative: _____
☐ Other: _____		Relative: _____

Current / Past Illness (Operation / Serious Illness)

☐ Cancer	Bowel / Prostate / Breast / Lung / Skin / _____
☐ Blood Pressure	High / Low
☐ Cholesterol	High / Low
☐ Diabetes	Type 1 / Type 2
☐ Heart Disease	Stroke / Heart Attack
☐ Osteoarthritis / Osteoporosis	
☐ Asthma	
☐ Previous Operations	_____
☐ Other	_____

Allergies	**Reaction**
☐ No Known Allergies	
☐ Penicillin	Rash / Coughing / Sweats / Vomiting / _____
☐ Codeine	Rash / Coughing / Sweats / Vomiting / _____
☐ Other Medication _____	Rash / Coughing / Sweats / Vomiting / _____
☐ Peanut	Rash / Coughing / Sweats / Vomiting / _____
☐ Other _____	Rash / Coughing / Sweats / Vomiting / _____

SOCIAL HISTORY

Occupation: _____ Retirement date: _____

Marital Status: *Single____ Married____ Separated____ Divorced____ Widowed____ Other* _____

Does the patient have any children? Yes / No How many: _____

Is the patient an "Elite Athlete": Yes / No

Live with: Spouse / Relatives / Friend / Alone

Are you a carer for someone? Yes / No

Do you have a carer? Yes / No / Self

Carer's Name: _____ Carer's Relationship to you: _____

Do you wish to identify yourself as belonging to a specific religious group? ……..

SMOKING HISTORY

Non Smoker / Ex-Smoker / Smoker

Cigarettes / Cigar / Pipe

Year Started _____

Number per day _____

Year Stopped _____

Please circle Status

Not ready to quit / Ready to Quit / Attempted to quit / Quit

ALCOHOL HISTORY

Non Drinker / Occasional / Moderate / Heavy

Year Started _____

Year Stopped _____

Days per week _____

Standard Drinks per day _____