CGMC CASEY GATE MEDICAL CENTRE BULK BILLING

New Patient Registration & Consent Form

33-34 Mack Road, Narre Warren South VIC 3805

TITILE: MR ☐ MRS ☐ MS ☐ MISS ☐ MASTER ☐ OTHER ☐

SURNAME/FAMILY NAME: _____

GIVEN NAMES: _____

MALE ☐ FEMALE ☐ OTHER ☐

MARITAL STATUS: Married ☐ Single ☐ Divorced ☐ Defacto ☐ Widowed ☐ Other: _____

DATE OF BIRTH: ____/____/_____

OCCUPATION: _____

MEDICARE NUMBER: _____ Ref. No.: _____ Expiry: ____/____/_____

PENSION/HEALTH CARE CARD NO: _____ Expiry: ____/____/_____

DVA NUMBER: _____ Expiry: ____/____/_____

RESIDENTIAL ADDRESS: _____

_____ POSTCODE: _____

CONTACT DETAILS:
Home: _____ Mobile: _____
Work: _____
Email: _____

EMERGENCY CONTACT OR NEXT OF KIN:
Name: _____
Phone number: _____
Relationship to patient: _____

ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER? YES ☐ NO ☐

COUNTRY OF BIRTH? _____

IF BORN OVERSEAS, YEAR OF ARRIVAL? _____

ARE YOU A REFUGEE? YES ☐ NO ☐

LANGUAGE SPOKEN AT HOME: _____ DO YOU NEED AN INTERPRETER? YES / NO (Please circle)

CIGARETTES:
NEVER SMOKED ☐ SMOKER ☐ EX-SMOKER ☐
No. per day:_____ Year started?_____
When did you quit? _____

ALCOHOL: Do you drink alcohol? YES ☐ NO ☐
How many days per week? _____ How many drinks/day? _____

FAMILY MEDICAL HISTORY: (Have any members of your family been diagnosed with or suffered from the following? Tick if YES and state who)
Diabetes: ☐ _____
Asthma: ☐ _____
Heart Disease: ☐ _____
Depression: ☐ _____
Other: ☐ _____

DO YOU HAVE ANY ALLERGIES? (Please specify) YES ☐ NO ☐ _____

SMS REMINDERS (RECALLS) **YES** ☐ NO ☐ We use SMS reminders for recall notifications? Do you consent?

OFFICE USE ONLY:

☐ Dr Amena Azizi
☐ Dr DaMing Chi
☐ Dr Rupali Kahyap
☐ _____

DATE: ____/____/_____
☐ Recall ☐ Scan
Doctor's Signature:_____

AGPAL ACCREDITED GENERAL PRACTICE

ARE THERE ANY ONGOING CONDITIONS? (e.g. High blood pressure, Depression, Arthritis etc.)	YES ☐ NO ☐	If YES, what are they? _____
ARE YOU CURRENTLY ON ANY MEDICATIONS?	YES ☐ NO ☐	If YES, what are they? _____
ARE YOU CURRENTLY TAKING ANY OTHER SUBSTANCES? (e.g. Naturopathic, Vitamins etc.)	YES ☐ NO ☐	If YES, what are they? _____
HOW DID YOU FIND US?		_____

PATIENT HEALTH IMFORMATION CONSENT

CONSENT FOR BULK BILLING: **(<u>If NO, you will have to pay for your consultation on the day via CASH or EFTPOS</u> - Please see reception for our fees)**	**YES** ☐ NO ☐	Bulk Billing is when your health professional accepts the Medicare benefit as payment for a service. We Store for later transmission and process them at the end of the day. "I assign/offer to assign my right to benefits to the practitioner who has rendered the services(s), or in the case of requested pathology, the approved pathology practitioner who will render the requested pathology service(s)"

You can decline to have your health information used as outlined below, but it may influence our ability to manage your health care to provide the best outcome for you.

I understand that my personal health information will be used for administrative purposes, plus disclosure to others involved in my healthcare as well as for scripts, referrals, reports, and tests by nurses, doctors and specialists within and outside this Medical Practice.	☐
I understand that my data may be used in research and quality assurance activities to improve individual and Community Health Care and Practice Management. This may occur when our practice incorporates patient health records into de-identifiable patient information to transfer to a third party. **De-identifiable patient information cannot be traced back to the individual.**	
I understand I may be part of the practice's national state and territory recall and reminder systems relevant to my healthcare e.g. Pap Smear Registry, Bowel Cancer Registry, Australian Immunisation Registry (AIR)	
I understand that <u>IF</u> my information is to be used for any other purpose other than set out above, my further consent will be obtained.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient's Name: _____

Date: _____/_____/_____

Patient's Signature: x_____

Signature of Parent/Guardian of Child: x_____

Name of Parent / Guardian: (please print) _____

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