Coastal Health Medical Centre
NORTH WYONG

PATIENT REGISTRATION FORM

PLEASE COMPLETE ALL SECTIONS AND RETURN TO THE FRONT DESK

PATIENT INFORMATION

Title	☐ Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____		
Surname:		**First Name:**	
Middle Name:		**Preferred Name:**	
Date of Birth:	/ /	**Country of Birth:**	
Birth Sex:	☐ Male ☐ Female	**Gender identity:**	☐ Male ☐ Female ☐ Non-binary ☐ Transgender
Ethnicity:	☐ Australian (Non-Indigenous) ☐ Australian Aboriginal ☐ Australian Torres Strait Islander ☐ Australian Aboriginal & Torres Strait Islander ☐ Other: _____		
Street Address:			
	Suburb:	Postcode:	
☐ Own home ☐ Relative's home ☐ Other private house ☐ Hostel ☐ Rental home ☐ Homeless ☐ Nursing home			
Phone:	Home Ph:	Work Ph:	
	Mobile:	☐ I do not consent to SMS appointment reminders	
***Workers Compensation**	Insurance Company:	Claim Number:	
	Return To Work Officer:	Phone:	
Preferred contact:	☐ Mobile ☐ Home Phone ☐ Work Phone ☐ Email		
Email address:			
Medicare No.	☐☐☐☐☐☐☐☐☐☐ Ref. No. ☐ Exp. Date ___/_____		
Pension/ No.	Exp. Date ____/_____/_____		
Pensioner card type:	☐ Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Senior's Card		
DVA number:	☐ Gold ☐ White ☐ Yellow		
Religion:			
Emergency Contact:	Name:	Contact Number:	Relationship to you:
Next of Kin: **Tick if same as above** ☐	Name:	Contact Number:	Relationship to you:
Occupation:			
Australian Defence Force:	☐ Never Served ☐ Current - Permanent ☐ Current – Reserves ☐ Past – Permanent or Reserves		
Marital Status:	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed		
Carer details:	Are you a carer? ☐ *Yes ☐ No Do you have a carer? ☐ *Yes ☐ No ***Details** Name: _____ Contact Number: _____ Relationship to you: _____		

Internal office use only: Medicare card validated Yes/No V1
Health Identifier Checked Yes/No

Our staff are trained and dedicated to serve you, and you will always be treated with courtesy and respect.
In return, we request that our doctors, staff, and nursing team are treated with the same courtesy and respect.
We have a zero tolerance policy in relation to any form of abuse or aggression. Anyone displaying this behaviour will be asked to leave the practice.

Family History

Mother alive? ☐ Yes ☐ No Age at death: _____ Cause of death: _____

Father alive? ☐ Yes ☐ No Age at death: _____ Cause of death: _____

Have you ever had a family history of:

Diabetes:	☐ Mother	☐ Father	**Hypertension:**	☐ Mother	☐ Father
Heart Disease:	☐ Mother	☐ Father	**Stroke:**	☐ Mother	☐ Father
Colon Cancer:	☐ Mother	☐ Father	**Depression:**	☐ Mother	☐ Father
Breast Cancer:	☐ Mother				

Alcohol:

☐ Non-drinker
☐ Drinker: Days per week _____ Drinks per day: _____
☐ Ex-drinker: (please circle) Occasional / Moderate / Heavy

Smoking:

☐ Non-smoker ☐ Smoker: Number of cigarettes per day: _____
☐ Ex-smoker Year started: _____ Year stopped _____
☐ Light ☐ Moderate ☐ Heavy

Allergies:

☐ NO Allergies ☐ Allergies **Please list any drug, food or other allergies you have:**
Allergy_____**Reaction**_____**Severity**_____
Allergy_____**Reaction**_____**Severity**_____

How did you hear about us?

☐ Family/Friend ☐ Website ☐ Facebook ☐ Leaflets ☐ Window signage
☐ Word of mouth ☐ Other _____

This practice is registered for the My Health Summary program which is a digital health program allowing us to easily share information between the healthcare providers involved in your care.

☐ Please tick this box if you do not consent to the My Health Summary Program

PRIVACY STATEMENT & FINANCIAL CONSENT

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Coastal Health Medical Centre collects information from you for the primary purpose of providing quality health care. 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. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare Australia requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals
- To contact you or your family for the purposes of Recalls & Reminders

Patient information shall not be released to a third party without the expressed consent of the patient.

I have read the information above and understand the reasons why my information is collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me. I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances. 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 planning and managing my health care. I accept financial responsibility for my account and agree to pay any outstanding fees.

PLEASE TICK THIS BOX & INITIAL

☐ I understand that in-line with RACGP guidelines relating to the management of chronic pain & mental health conditions, that **the Drs at Coastal Health Medical Centre WILL NOT prescribe Schedule 8 & Schedule 4 drugs (drugs of dependence) at the first visit or on an ongoing basis.** _____ **Initial**

Name: _____

Signed _____ Date _____