Patient Registration & Privacy Form

Title:	Mr	Mrs	Ms	Mast	Miss	Gender:	Male	Female	Date of birth:	/ /
First Name:						Surname:				
Medicare Card:							**Medicare Ref No**:		Expiry date:	/ /
Pension/ Health Card/ Veterans Affairs no. if any:						Type of Veterans Affairs card :			Expiry date:	/ /
Occupation						Country of Birth:				
Home Address:									Post code:	
Phone: Home:						Work:			Mobile:	
Email:										

Are you Aboriginal or Torres Strait Islander (ATSI) : No / Yes (specify): Aboriginal Torres Strait Islander

Allergies: Are you allergic or sensitive to any Medications: Y / N. If so, Please specify :

Emergency Contact: Name		Relationship:		Contact no:	

Social History		***Family History***					
Do you Smoke? How many per day / week?		Married:		De facto:		Single	
Have you smoked previously? Quit date?		How many children do you have?					
Drink Alcohol? How many per day / week?		Boys:		Ages:		Deceased:	
Recreational drugs? How often?		Girls:		Ages:		Deceased:	
Do you want to quit any / all of the above?		Are your Parents alive?					

Confidential Past Medical History	
Have you ever been a patient in a hospital?	
If so, for what reason?	
If so, please specify where and when?	
Are there any chronic disease/s you have suffered /currently suffer from?	
Are there any other temporary medical conditions you suffer from?	
What health concern do you want to discuss today?	
Do you take regular medications? Please list below	

For Staff use only:

MEDICARE CHECKED ☐ PHOTO ID CHECKED ☐

Privacy Agreement & Patient Consent:

I understand that Hanson Medical centre and Associate Medical Centres comply with the privacy act (1988) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Hanson Medical Centre collecting, using , storing and disposing of my personal information, the release of personal information to other health professionals to allow quality medical care; inclusions in a recall register to be advised of follow up visits: inclusion in national/ state reminder system/registers, medical updates and health information and the release of relevant personal information to my (Prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Hanson Medical Centre to use and disclose my personal information (except when legal obligations must be met).

Patients Signature: Date: