PATIENT REGISTRATION FORM

Green Tree Medical is committed to providing our patients with the finest care. To establish this, it is essential that your personal health record is kept up to date and accurate.

Please complete all sections of this form:

Title:	☐ Mr ☐ Mast ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other:		
Surname:			
First Name:			
Middle Name:		**Date Of Birth:**	
Street Address:			
Postal Address: (if different to street address)			
Mobile Phone:	**Home Phone:**	**Work:**	
Email:		**Sex:** ☐ Male ☐ Female	
Medicare Number:		**Ref No:**	**Expiry Date:**
DVA Gold / White:			**Expiry Date:**
Pension / HCC Number:	**Type:**		**Expiry Date:**
Private Health Fund	**Number:**		**Expiry Date:**
Next of Kin:	Full Name:		
	Address:		
	Contact Phone No:	Relationship to patient:	
Emergency Contact: (if different from Next of Kin)	Full Name:		
	Address:		
	Contact Phone No:	Relationship to patient:	
Occupation: **Retired** ☐	Occupation_____ Employer_____ Does the nature of your visit relate to a work place injury: ☐ Yes ☐ No Is your employer insured under: ☐ WorkCover Queensland ☐ Self Insured Claim Number (if applicable)_____		
ADF Services	☐ Never served ☐ Currently Serving - Permanent member ☐ Currently Serving – Reserve ☐ Past ADF member – Permanent or Reserve		
Cultural Identity	**To assist with health initiatives – do you identify as Aboriginal and/or Torres Strait Islander?** ☐ - Aboriginal ☐ - Aboriginal Torres Strait Islander ☐ - Torres Strait Islander ☐ - Australian – Non Indigenous ☐ Other _____		
Communication	**Preferred method of contact** ☐ Mobile ph ☐ Work ph ☐ Home ph ☐ SMS ☐ Email ☐ Letter **Are you happy to receive SMS messages from Greentree Medical relating to your appointments?** ☐ Yes ☐ No **Are you happy to receive emails from Greentree Medical Practice relating to practice information?** ☐ Yes ☐ No		

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green tree MEDICAL

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Weight: _____ Kgs	Height: _____ cms

Significant Family History

Unknown (Adopted) ☐

Mother Alive:	Yes ☐ No ☐	Age at Death:	Cause of Death:	
Father Alive:	Yes ☐ No ☐	Age at Death:	Cause of Death:	
Mother:	Diabetes ☐	Hypertension ☐	Heart Disease ☐	Stroke ☐
	Colon Cancer ☐	Depression ☐	Breast Cancer ☐	
Father:	Diabetes ☐	Hypertension ☐	Heart Disease ☐	Stroke ☐
	Colon Cancer ☐	Depression ☐		

Other Family Members with Significant History: - **if a grandparent please state if maternal or paternal**

Family Member:_____ Condition_____

Family Member:_____ Condition_____

I **DO NOT** suffer from any known allergies - ☐

I **DO** suffer from an allergy

Known Allergy (one allergy per line)	**Reaction No*** (select one reaction only)	**Severity of Allergy** (circle one per allergy)		
1._____	_____	Mild	Moderate	Severe
2._____	_____	Mild	Moderate	Severe
3._____	_____	Mild	Moderate	Severe

Reaction No* (please select which reaction relates to your known allergy and write the corresponding number next to your known allergy)

1. Anaphylaxis	5. Diarrhoea	9. Vomiting	13. Weight Gain
2. Chest Pain	6. Nausea	10. Pruritus/Itching	14. Other_____
3. Muscle Pains	7. Oedema/Swelling	11. Urticaria/Hives	
4.Bronchospasm/Asthma	8. Rash	12. Drowsiness	

Alcohol Intake

Non Drinker ☐	
Days per week you drink alcohol (circle one) 1 2 3 4 5 6 7	Approx. how many standard alcoholic drinks would you consume on the day you have circled_____

Smoking History

Non Smoker ☐	Ex-Smoker ☐	Smoker ☐
What year did you start smoking_____	How many cigarettes do you smoke per day_____	
If you no longer smoke, what year did you stop_____		

Marital Status

Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐

Sexuality (OPTIONAL)

Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other ☐

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Patient Consent

Please read this consent form carefully prior to signing.

This general practice 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 and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- 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.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

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Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian) _____

PRACTICE USE ONLY:

Witnessed by: (staff signature) _____

Date: _____ / _____ / _____