Welcome to Tweed City Family Practice

Title: Miss / Mrs / Ms / Mr / Master / Other:_____

First Name: _____ **Middle Name:** _____ **Surname:**_____

Known As: _____ **Date of Birth**:_____ / _____ / _____

Gender: Female / Male / Transgender

To assist with health initiatives, do you identify as Aboriginal or Torres Strait

Islander: ☐ No ☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Both

If yes, please ask at reception about registering for the Close The Gap initiative

Ethnicity: Australian / European / Maori / New Zealander / Caucasian / Asian /

Other: _____

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ **Ref:** __ **Exp Date:** _ _ / _ _

Health Care Card/Pension Card: _ _ _ - _ _ _ - _ _ _ _ **Exp Date:** _ _ / _ _ / _ _

DVA Card: _ _ _ _ _ _ _ _ **Exp Date:** _ _ / _ _ / _ _ ☐ All ☐ Specified

Street Address: _____

Suburb: _____ **State:**_____ **Post Code:** _____

Ph: _____ **Work:** _____ **Mobile:** _____

Email: _____

Next of Kin:

Full Name: _____ Ph: _____ Relationship: _____

Emergency Contact: ☐ *Please tick if same as Next of Kin*

Full Name: _____ Ph: _____ Relationship: _____

Marital Status: Single / Married / Widowed / Divorced / Defacto / Separated

Occupation: _____

Country of Birth: _____

Year of arrival in Australia (if born outside of Australia):_____

Spoken Language: _____ **Preferred Language:** _____

Do you require a translation or Interpreter Service? ☐ No ☐ Yes

*** Is your visit related to Workcover?** *If yes, please advise the following:*
Is this a new or existing Claim: _____ Claim No: _____
Employer:_____ Insurance Company: _____

*** Do you have private health insurance?** Yes / No

ALL PATIENTS TO SIGN CONSENT FORM BELOW

Consent form:

This practice adheres to the Australian Privacy Principles (2014) from Schedule 1 of the Privacy Amendment (Enhancing Privacy Protection) Act (2012), which amends the Privacy Act (1988), Federal Privacy Act (1988), and NSW Health Record and Information Act (2002). A current copy of these Acts can be found on the Comlaw website, www.comlaw.com.au and a copy of our Practice Privacy Policy is viewable upon request.

To enable ongoing care and total quality improvement within this practice, and in keeping with the abovementioned Acts, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent. By signing below, you (as a patient/guardian) are consenting that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventative health care via SMS, letter or phone call
- For accounting procedures and the collection of professional fees
- The diagnosis and treatment of any condition, including the communication of relevant information only, to practice staff, specialists and other health care providers to ensure quality care is provided
- Accreditation and Quality Assurance activities are conducted by professionally trained, non-treating GP's and other professionally trained and qualified persons, eg. General Practice Managers
- For legal related disclosures as required by the court of law
- For disease notification as required by law
- For use when seeking treatment by other doctors in this practice
- For the purpose of obtaining medical records, previous clinical reports and management regimes, etc from other medical practitioners, institutions, laboratories etc.
- To inform the next of kin identified in my patient information of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent
- I agree to notify Tweed City Family Practice of any changes of personal details as soon as they become available, such as change of address, phone, emergency contact etc.

By signing below, you are indicating your **consent** for the above mentioned.

Signed: _____ Date: _____

Name:_____

If signing on behalf of the registering patient, please state your relationship to the patient: _____

Page 2: Patient Name:_____ DOB:_____

PLEASE TAKE THIS PAGE IN TO YOUR DOCTOR – FIRST PAGE MUST BE GIVEN TO RECEPTION

ALLERGIES

Do you have any allergies or are you sensitive to any drugs or dressings?

YES / NO If yes, please list: _____

MEDICATIONS

Please list your current medications (including over the counter medications, vitamins and herbal supplements)

Medication	Strength	Dose

MEDICAL HISTORY AND CURRENT CONDITIONS

Do you suffer from any of the following? (please circle)

Hypertension Asthma Heart Disease Diabetes (Type 1 or 2)

Have you had any previous operations? If yes, please list:

Type:_____ Year:_____

_____ _____

_____ _____

Any other information or conditions: _____

_____

FAMILY MEDICAL HISTORY (Identify Mother/Father/Brother/Sister etc)

Diabetes: _____ Heart Disease: _____

Asthma: _____ Cancer (& Type): _____

Mental Illness: _____ Other: _____

SOCIAL MEDICAL HISTORY

*Are you an elite athlete? YES / NO

*In your current or previous occupation, have you had any exposure to:

Asbestos Dust Radiation Animals

*How often do you have a drink containing alcohol?

□ Never □ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week

*How many standard drinks containing alcohol do you have on a typical day? □ N/A

□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

*How often do you have 6 or more drinks on one occasion?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Do you consider alcohol consumption a problem for you? □ Yes □ No

*Current Smoking History: Never Smoked Smoker Ex-Smoker

If Ex-Smoker, Year Started:_____ Year Stopped:_____

If Smoker, how many per day:_____

*Are you a traveler? ☐ Or are you a local resident? ☐

Your medical record is confidential. Please take this page in to your doctor, ensuring that page 1 has been handed in at reception.

Thank you

DOCTOR USE ONLY

Entered into Medical Director : Y / N