PRACTICE REGISTRATION FORM

PATIENT INFORMATION:

Title	☐ Mr ☐ Master ☐Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____		
Surname:		**First Name:**	
Middle Name:		**Preferred Name:**	
Date of Birth:	/ /	**Country of Birth:**	
Sex:	☐ Male ☐ Female ☐ Other		
Ethnicity:	☐ Australian (Non-Indigenous) ☐ Australian Aboriginal ☐ Australian Torres Strait Islander ☐ Australian Aboriginal & Torres Strait Islander ☐ Other: _____		
Street Address:			
	Suburb:	Postcode:	
Phone:	Home Ph:	Work Ph:	
	Mobile:		
Preferred contact:	☐ Mobile ☐ Home Phone ☐ Work Phone		
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:			
Language Spoken:			
Emergency Contact:	Name:	Contact Number:	Relationship to you:
Next of Kin: **Tick if same as above** ☐	Name:	Contact Number:	Relationship to you:
Previous Occupation:			

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Australian Defence Force:	☐ Never Served ☐ Current - Permanent ☐ Current – Reserves ☐ Past – Permanent or Reserves
Marital Status:	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

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	☐ Father			

Alcohol:	**Current Alcohol intake:** ☐ Non-drinker How many days a week do you drink? _____ Number of standard drinks per day: ____ **Past Alcohol intake:** ☐ Occasional drinker ☐ Moderate drinker ☐ Heavy drinker Year started: _____ ☐ Ex-drinker: Year stopped _____
Smoking:	**Current Smoking history:** ☐ Non-smoker ☐ Ex-smoker ☐ Smoker Number of cigarettes per day: _____ **Past Smoking history:** ☐ Light ☐ Moderate ☐ Heavy Year started: _____ Year stopped _____
Allergies:	☐ No allergies ☐ Allergies **Please list any drug, food or other allergies you have:** Allergy__ _____ Reaction_____ Severity_____
Vision Status:	☐ Impaired ☐ Not Impaired **Do you use hearing aids:** ☐ Yes ☐ No
Hearing Status:	☐ Impaired ☐ Not Impaired **Do you wear glasses:** ☐ Yes- always ☐ Reading only ☐ No

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

Integrated Clinical Healthcare

PRIVACY STATEMENT

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

Integrated Clinical Healthcare 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.

Name: _____

Signed _____ Date _____

I accept these fees will be payable to Integrated Clinical Healthcare.

Joining the practice

- Patients joining our practice are advised to book a 'New Patient Consult' (30 minutes) for their first appointment. This incurs a gap payment of $95.00 in addition to the standard Medicare Charge.
- This fee covers a consult with your new GP covering your existing health needs, discussing your health aspirations, a medication review and organising any additional tests and follow-ups required.

GP Consult fees

- A 'Standard Consult" (15 minutes) Gap payment of $45.00
- A 'Long Consult" (30 minutes) Gap Payment of $95.00
- A 'Telephone consult' Gap payment of $20.00
- A home-based visit can be booked where the GP will visit the patient at home. This incurs a Gap payment of $95.00
- Enhanced services, specialist and allied health visits will incur a gap payment.

NOK Name:

NOK Phone No:

NOK Signature: