SHENTON AVENUE MEDICAL CENTRE

**3a/94 Delamere Avenue**

**Currambine, WA, 6028**

**Telephone: (08) 9305 3232**

**Fax: (08) 9304 0334**

**Patient Registration Form**

**We are committed to providing our patients with the highest standards of care. In order to do this, it is essential that your health records are kept up to date and accurate.**

|  |
| --- |
| Could you please assist us by completing the following: |
| Title |  € Dr € Mr € Mrs € Ms € Miss € Master (please tick) |
| First Name:  |  Middle Name: Surname:  |
| Known As:  |  Date of Birth Sex: |
| Country of Birth:  |  Year of Arrival in Australia: Ethnicity: |
| Street Address: |  |
| Suburb:  |  State: Post Code: |
| Home: |  Mobile No: |
| E-mail: |  |
| Medicare Number: | Ref No: | Expiry: |
| € DVA Gold € DVA White (please Tick) | No: | Expiry: |
| Pension Number |  No: | Expiry: |
| Health Care Card Number |  No: | Expiry |
| Private Health Cover: Name of Fund: |  | Member No: |
| Next of Kin Relationship: | Name:Tel: |
| Emergency Contact (name and phone number of a the person we can contact if needed) | Name:Tel: |

**Patient Background**

**Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.**

|  |
| --- |
| Do you identify as someone from a culturally and/or linguistic diverse background? |
| € No€ Yes (please elaborate) |
| To assist with health initiatives- are you of Aboriginal or Torres Strait Islander descent? |
| € No€ Yes- Aboriginal€ Yes- Torres Strait Islander€ Yes- Aboriginal & Torres Strait Islander |

**History**

|  |
| --- |
| Do you have or have you had a history of the following? ( please elaborate) |
| € Operations/Surgery |
| € Asthma |
| € Diabetes |
| € Hypertension |
| € Chronic Illness |
| Do you have any allergies or are you sensitive to any drugs or dressings?€ No € Yes (please specify) |

**Immunisations**

|  |
| --- |
| Have you had the following Immunisations? (list date where appropriate) |
| Tetanus Booster | **€ Yes Date:** | **€ No** | **€ Unsure** |
| Hepatitis B | **€ Yes Date:** | **€ No** | **€ Unsure** |
| Hepatitis A | **€ Yes Date:** | **€ No** | **€ Unsure** |
| Influenza | **€ Yes Date:** | **€ No** | **€ Unsure** |
| Pneumococcal | **€ Yes Date:** | **€ No** | **€ Unsure** |
| Polio | **€ Yes Date:** | **€ No** | **€ Unsure** |

**Children’s Immunisations**

|  |
| --- |
| If completing this form for a child, are their immunisations up to date? |
| € Yes€ No |

 **Current Medications**

|  |
| --- |
| Please list all current medications and dosage, including over the counter medications, vitamins, minerals and supplements. |
|  |

**Reminder Systems**

**Our practice provides our patients with preventative care and early case detections reminders e.g. immunisations, annual health checks, skin checks and pap smears.**

|  |
| --- |
| Do you wish to have any relevant health reminders sent to you? |
| € Yes- my mail€ Yes- by E-mailEmail:€ Yes- by SMS alertsMobile: | **€ No** |
| If we need to contact you, what is tour preferred method of contact? |
| € Home Phone€ Mobile | **€ Mail****€ E-mail** |
| Are there any health concerns that you would like to receive information on? |
|  |

**Family History**

|  |
| --- |
| Have any members of your family had the following: (please specify) |
| € Heart disease |
| € Asthma |
| € Diabetes |
| € Mental Illness |
| € Cancer |

**Social History**

|  |
| --- |
| Do you use any of the following: (list amounts where appropriate) |
| Tobacco | **€ No****€ Yes. Number \_\_\_\_\_\_ day/\_\_\_\_\_\_ week or****€ Ceased smoking** |
| Alcohol | **€ No****€ Yes. Number\_\_\_\_\_\_day/\_\_\_\_\_\_\_\_week/\_\_\_\_\_\_\_month** |
| Drug Use | **€ No****€ Yes. Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Measurements**

|  |
| --- |
| Height: \_\_\_\_\_\_\_\_\_\_\_ cm |
| Weight: \_\_\_\_\_\_\_\_\_Kg |

**Blood Pressure**

|  |
| --- |
| When was the last time your blood pressure was taken? |
|  |

**Sun Protection**

|  |
| --- |
| How often do you use the following to protect yourself from the sun when outdoors? |
| Protective Clothing | **€ Always** | **€ Often** | **€ Sometimes** | **€ Rarely** | **€ Never** |
| SunscreenCreams | **€ Always** | **€ Often** | **€ Sometimes** | **€ Rarely** | **€ Never** |

**For those 65 years and older:**

|  |
| --- |
| When was the last time you were immunised? |
| Influenza | **Date:** | **€ Not Sure** | **€ Never** |
| Pneumococcalpneumonia | **Date:** | **€ Not Sure** | **€ Never** |

**Females**

|  |
| --- |
| When did you last have? |
| Pap Smear | **Date:** | **€ Not Sure** | **€ Never** |
| Breast Check | **Date:** | **€ Not Sure** | **€ Never** |

**Males**

|  |  |  |  |
| --- | --- | --- | --- |
| **Overall Check-up** | **Date:** | **€ Not Sure** | **€ Never** |
| **Prostate Check** | **Date:** | **€ Not Sure** | **€ Never** |

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**PRIVACY STATEMENT**

**Introduction**

We are committed to protecting the privacy of patient information and to handling your personal information in a responsible manner in accordance with the Privacy Act 1988 (Cth), the Privacy Amendment (Enhancing Privacy Protection) Act 2012, the Australian Privacy Principles and relevant State and Territory privacy legislation (referred to as privacy legislation).

This Privacy Policy explains how we collect, use and disclose your personal information, how you may access that information and how you may seek the correction of any information. It also explains how you may make a complaint about a breach of privacy legislation.

This Privacy Policy is current from 2014. From time to time we may make changes to our policy, processes and systems in relation to how we handle your personal information. We will update this Privacy Policy to reflect any changes. Those changes will be available on our website

and in the practice.

**Collection**

We collect information that is necessary and relevant to provide you with medical care and treatment, and manage our medical practice. This information may include your name, address, date of birth, gender, health information, family history, credit card and direct debit details and contact details. This information may be stored on our computer medical records system and/or in hand written medical records.

Wherever practicable we will only collect information from you personally. However, we may also need to collect information from other sources such as treating specialists, radiologists, pathologists, hospitals and other health care providers.

We collect information in various ways, such as over the phone or in writing, in person in our practice. This information may be collected by medical and non-medical staff.

In emergency situations we may also need to collect information from your relatives or friends.

We may be required by law to retain medical records for certain periods of time depending on your age at the time we provide services.

**Use and Disclosure**

We will treat your personal information as strictly private and confidential. We will only use or disclose it for purposes directly related to your care and treatment, or in ways that you would reasonably expect that we may use it for your ongoing care and treatment. For example, the disclosure of blood test results to your specialist or requests for x-rays.

There are circumstances where we may be permitted or required by law to disclose your personal information to third parties. For example, to Medicare, Police, insurers, solicitors, government regulatory bodies, tribunals, courts of law, hospitals, or debt collection agents. We may also from time to time provide statistical data to third parties for research purposes.

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

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR**

**My Signature below indicates that I consent to the handling of information by this practice for the purposes set out above on behalf of my child:**

**Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**