HEALTHworks healthcare

Patient Registration Form

Date:_____

Title:_____ First Name:_____ Surname:_____Date of Birth_____

Address:_____

_____

Contact Numbers: H:_____ W:_____M:_____

Occupation:_____ Name of employer_____

Doctor's Preference: □ Dr Shahid Ghafoor □ Dr Buddhi Wickramasinghe □Dr Teslin Mathews (psychiatrist)

□ Consent to receiving any text communication from the practice to the mobile number given above

Were you born in Australia? □ Yes □ No
If not, where were you born: _____ Cultural Background:_____(Greek/Indian/Italian)

Who do you live with at home: _____

ATSI (Please Tick)
□ Aboriginal □ Torres Straight Islander □ Aboriginal and Torres Straight Islander

Medical History (Please Tick)
□ Alcohol □ Smoking □ Allergies
Smoking - how many per day: _____
Are you ex-smoker □ Yes □ No What date did you give up smoking:_____

Alcohol – how often you drink:_____How many standard drink per day:_____
How often would you have 6 or more drinks on any one occasion:
□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily
Are you concerned about drinking: □ Yes □ No

Any Family History Of: □ Cancer □ Diabetes □ Heart Disease □ Stroke

Email Address:_____

Next of kin/ In case of Emergency:_____

Relationship:_____Contact number:_____

Emergency contact if different to the N.O.K:_____

Relationship:_____Contact number:_____

Medicare Number:_____Ref no.:_____ Valid to:_____

Pension Card Number:_____Valid to:_____

Health Care Card Number:_____Valid to:_____

D.V.A Card Number:_____Valid to:_____

Consent:

Patients Signature:_____

Note: Missed appointments attract a fee of $35 for a single appointment and $70 for a double missed appointment. Cancellations without at least 12 hours notice may also attract a charge. I also agree to the enclosed Health Information & Use Consent Form. Consultations - No gap fee for Pensioners over 65, Children under 16 and DVA card holders.

47 Edwards Road, Kennington, Vic 3550 Ph: (03) 5442 2366 fax: (03) 5442 7037
Email: kennington@healthworks.net.au

Health Information Collection and Use Consent Form

As a patient of our medical practice 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.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes including, compliance with Medicare and Health Insurance Commission Requirements.
- Disclosure to others involved in your healthcare 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 returned to us following referrals.
- Disclosure to other doctors in the practice, locums ect. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt-out" of any involvement.
- To comply with any legislative or regulatory requirements eg. Notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	
I understand that if my information is to be used for any other purpose than set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	
Or	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	

Patients Name:_____ Date_____

Patients Signature: _____

Signed as Guardian for child:_____ Name (printed)_____