Airport Total Health Care Clinic
8 Cherie Street, Tullamarine VIC 3043
Tel: (03) 9338 7333 Fax: (03) 9338 8095
Email: athcc.medical@gmail.com

NEW PATIENT REGISTRATION FORM

We need this information to provide the best quality care. This form complies with the *RACGP Standards for general practices (5th edition)*. This means your personal information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

Personal Details

Title:	Surname:		Given Name:		
Date of Birth:	/ /				
Birth Sex:	Male ☐	Female ☐	Other ☐		
Gender Identity:	Male ☐	Female ☐	Non-Binary ☐	Gender Diverse ☐	Transgender ☐ Different Identity ☐
Marital Status:	Single ☐	Married ☐	De facto ☐	Separated ☐	Divorced ☐ Widowed ☐
Home Address:					
Postal Address:	☐ Same as above				
Home Phone:		Work Phone:		Mobile:	
Email:					
Occupation:					
Medicare Card Number:		Reference No:		Expiry Date:	
Health Care Card:				Expiry Date:	
Pension Concession Card:				Expiry Date:	
DVA Card:	Gold ☐	White ☐	No.:	Expiry Date:	
Next of Kin Person Name:		Relationship to you:		Phone Number:	
Emergency Contact Person Name:		Relationship to you:		Phone Number:	
Do you have an advance care directive for end of life care?	Yes ☐	No ☐	For more information, talk to your GP		

Cultural Background

Knowing your cultural background can help us provide healthcare that meets your individual needs.
Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

Cultural Background (Ethnicity):	Country of birth:
Is English your first language? ☐ Yes ☐ No	
If not, do you require an interpreter? ☐ Yes ☐ No	If yes, please specify language:

Smoking and Alcohol History

Smoking	**Alcohol**
☐ Non Smoker	☐ Non Drinker
☐ Ex-Smoker	☐ Ex-drinker
☐ Smoker Date Started: /day	☐ Drinker /day How many days per week:
Do you use recreational drugs? ☐ Yes ☐ No	If Yes, details:

Please list the name of your previous and/or other current GP Doctor or Clinic, taking care of your health condition:

Health History

Any allergies or are you sensitive to drugs or dressings?	☐ Yes (please list with nature of reaction) ☐ No
Any significant illness or condition:	
Any surgeries:	
Current Medications:	
What Immunisation have you had?	
Any Significant illness/Condition in the family:	
Height (in cms):	Weigh(in kgs):

Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for your appointment, procedures such as vaccinations, Pap tests and other health reviews.	**I consent to being contacted with reminders to help me maintain my health**	☐ **YES** ☐ **NO**
Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders, which can be helpful if you move.	**I consent to being contacted with reminders to help me maintain my health**	☐ **YES** ☐ **NO**

Transfer of Health Information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the reception for information about how this can take place.

PATIENT INFORMATION PRIVACY POLICY

This Medical Practice Requires Your Consent….
We ask you to provide us with your personal details and **full medical history** so that we may properly assess, diagnose, treat, and be proactive in your health care needs.

**** Please note, this practice reserves the right to discontinue treatment ****
Where information given by the patient is incorrect or incomplete.

Your information will be used for:

- Administration purposes in running our practice.
- Billing purposes, including complying with the requirements of Medicare and the Health Insurance Commission.
- Quality Assurance activities and research purposes such as accreditation (patient identity will not be disclosed).
- For infectious disease notification – as required by law.
- For legal purposes, e.g. Subpoena or Court order – as required by law.
- Disclosure to others involved in your health care, including treating doctors, and specialists outside this medical practice, i.e. through referral, medical test, reports or results.
- Disclosure to other doctors or allied health professionals within this practice for the purpose of patient care.
- We send all our prescriptions electronically and may view the history of any of your prescribed or dispensed prescriptions.

If you do not wish for your records to be accessed for these purposes, please inform the doctor so that he may note this in your record.

I have read the information above and I …
Understand the reasons for patient information collection.
Understand this practice has a privacy policy on handling patient information
Understand that I am not obliged to provide the information requested, but that failing to do so might compromise the quality of health care treatment given to me.
Understand that if my information is to be used for any other purposes other than set out above, further consent must be obtained.
I am aware of my right to access the information collected except in circumstances where access might legitimately be withheld. Such circumstances will require explanation.

Signature of Patient or Guardian:	**Date: / /**
If Patient not Signing, Your Name and relationship to Patient:	