

Jimboomba Medical Centre – Patient Registration Form

STAFF USE: INITIALS OF STAFF MEMBER: \_\_  
☐ SCANNED ☐ MD ENTRY

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: .....

Given Name .....

Family Name .....

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I self-identify as: ☐ Aboriginal ☐ Torres St Islander  
☐ I do not self-identify as either Aboriginal or Torres St Islander

Medicare Number / DVA Number: \_\_\_\_\_ Ref. No.: \_\_\_\_\_

Medicare expiry date \_\_ / \_\_

If DVA: ☐ Gold ☐ White – conditions: .....

Concession Card No.: ☐ Pension Card ☐ Health Care Card  
..... Expiry date: .....

Your Address: ..... PostCode: .....

Mobile: ..... Home: .....

Email: .....

Are You? ☐ Single ☐ Married ☐ De Facto ☐ Widowed  
☐ Separated ☐ Divorced

Your Occupation: .....  
Australian Defence Force Personnel: ☐ Current ☐ Former  
Country of Birth: .....  
Languages Spoken:.....  
Self-identified Cultural background: .....  
Is an Interpreter needed for consultations ☐ Yes ☐ No

Next of Kin Full Name: .....

Address: ☐ As above (if not please write the address below)  
.....  
..... PostCode: .....

Contact No.: .....

Relation: .....

Emergency Contact ☐ Same as Next of Kin (proceed to next question)

Full Name: .....  
Address: ☐ As above (if not please write the address below)  
.....  
..... PostCode: .....

Contact No.: .....

Relation: .....

☐ No Known Allergies

OR fill in: Allergies	What happens

Smoking Assessment: ☐ Never ☐ Ex-Smoker ☐ Smoker  
☐ Started (year) \_\_\_\_ Quit (year) \_\_\_\_  
☐ Weekly ☐ Less than weekly ☐ Daily: How many per day \_\_\_\_

Alcohol Assessment: 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

Standards drinks containing alcohol do you have on a typical day? \_\_\_\_  
How often do you have six or more drinks on one occasion? \_\_\_\_

Year of last:  
Vaccination: Tetanus \_\_\_\_ , Flu Vaccine \_\_\_\_ , Pneumonia \_\_\_\_  
Females: Cervical screening \_\_\_\_ Mammogram \_\_\_\_  
Males: Prostate Check \_\_\_\_

How did you hear about us?  
☐ Word of Mouth (Friend / Family) ☐ Internet Search (eg. Google) ☐ Walk By ☐ School Newsletter ☐ Jimboomba Times ☐ Other: .....

Do you have a family history of:  
Asthma ☐ Mother ☐ Father ☐ Sibling  
Diabetes ☐ Mother ☐ Father ☐ Sibling  
Bowel Cancer ☐ Mother ☐ Father ☐ Sibling  
Breast Cancer ☐ Mother ☐ Father ☐ Sibling  
Heart Disease ☐ Mother ☐ Father ☐ Sibling  
High Blood Pressure ☐ Mother ☐ Father ☐ Sibling  
Arthritis ☐ Mother ☐ Father ☐ Sibling  
Osteoporosis ☐ Mother ☐ Father ☐ Sibling  
Other: ..... ☐ Mother ☐ Father ☐ Sibling

Do you have a current chronic health problem:  
☐ Asthma ☐ Diabetes: ☐ Type 1 ☐ Type 2  
☐ Heart Disease ☐ High Blood Pressure ☐ Arthritis ☐ Osteoporosis

Other Health Problems or Operations:  
.....  
.....

Medications you currently take (incl. strength)  
.....  
.....  
.....

PATIENT CONSENT

RECALL AND REMINDER SYSTEM: Jimboomba Medical Centre participates in National and State reminder Registers along with our own recall/reminder system. This clinic contacts patients via SMS (mobile text message), emails, phone calls and letters for: appointment reminders, recalls and preventive health reminders. At any point in time patients can withdraw their consent.

☐ YES I consent to being / my child being placed on the recall / reminder system and give permission for a message to be left on contact numbers supplied.  
☐ NO I Do Not consent to being / my child being placed on the recall / reminder system.

COLLECTION OF INFORMATION: 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 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 though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
  - Disclosure to other doctors in the practice, locums etc. 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 e.g. notifiable diseases.
  - For reminders which may be sent to you regarding your health care and management.
  - CCTV footage for the public safety and for the investigation and prosecution of criminal offences

At any time 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 consent to the collection of information and declare that all information provided on this form is accurate.

Signature: ..... Date: \_\_ / \_\_ / \_\_\_\_

Self ☐ Parent ☐ Other:.....