Sunnybank Plaza Family Clinic

# NEW PATIENT REGISTRATION FORM

**Welcome To Sunnybank Plaza Family Clinic, Registered General Practice**

To assist us in ensuring your information is correct, please complete the following details. Once completed, please hand to a receptionist along with your Medicare Card and your Pensioner Card/ Health Care Card if you have been issued with one.

称呼 **Title** ☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Mast. ☐Other _____

姓氏 **Surname** _____ 名 **Given Name** _____ 出生日期 **D.O.B.** / /

称呼 **Preferred Name** 婚姻状态 **Marital Status** 出生国家 **Birth Country**

性别 **Gender** ☐男性 Male ☐女性 Female ☐其他 Others _____ 职业 **Occupation**

种族 **Ethnicity**

☐ 澳大利亚人,不属原住民 Australian, non indigenous
☐ 原住民, 但不属太平洋岛民 Aboriginal but not Torres Strait Islander
☐ 原住民和太平洋岛民 Both Aboriginal & Torres Strait Islander
☐ 太平洋岛民,但不属 原住民 Torres Strait Islander but not aboriginal
☐ 其他, 请注明 Other, Please specify

地址 Address _____

社区名称 **Suburb** _____ 社区邮编 Post Code _____

住家电话 **Home phone** _____ 工作电话 **Work phone** _____ 手机电话 **Mobile** _____

电子邮件 **Email**

**Medicare 卡号:** _____ 个人代码 **Ref. No.:** 有效期限 **Expiry:** _____

低收入保证卡号 **Pensioner Card No.:** _____ 有效期限 **Expiry:** _____

额外健保卡号 **Healthcare Card No.:** _____ 有效期限 **Expiry:** _____

海外学生保險 **Overseas Student HC:** 名称 Name. 卡号 **No.** 有效期限 **Expiry:** _____

退伍军人卡号 **DVA Card No.:** ☐金卡 **Gold** ☐ 白卡 **White** ☐ 橘卡 Orange

直系亲属 **Next of Kin** 名 **Given Name** _____ 姓氏 **Surname** _____

地址 **Address** _____

联系电话 **Contact no.** 住家电话 **Home phone** 关系 **Relationship**

紧急联络人 **Emergency contact** 名 **Given Name** _____ 姓氏 **Surname** _____

地址 **Address** _____

联系电话 **Contact no.** 住家电话 **Home phone** 关系 **Relationship**

饮酒史 **Do you drink alcohol?** ☐有 YES ☐无 NO 多少 **How many?** _____ 每天 per day _____ 每周 Per week ☐ 社交 Socially

抽烟史 **Do you smoke?** ☐有 YES ☐无 NO 次数 **How many?** _____ 每天 daily ☐ 已戒烟者 Ex Smoker

过敏史 **Allergies** ☐有 YES ☐无 NO 如果有, 请注明: **If yes, Specify:**

日常用药 **Current medications** ☐有 YES ☐无 NO 如果有, 请注明: **If yes, Specify:**

您是怎么知道这个诊所？**How did you hear about our practice?**

**Please tick only if you do not want your health summary shared to MyHealth Record services.** ☐
若您不想將您在此診所的病歷分享到澳洲電子健康記錄系統，請打勾。
**Please note: if you do not want to participate, you need to contact My Health Record Help line: 1800 723 471.**
若您不想参与澳洲电子健康记录，請聯係澳洲電子健康記錄系統服務專綫：1800 723 471.

**請翻面後繼續填寫, 謝謝!** Please turn over and continue with the form, thanks!

| 既往病史 **PAST MEDICAL HISTORY:** | 有 **YES** | 无 **NO** | 请注明 **PLEASE SPECIFY** |
|---|---|---|---|
| 神经系统（包括脑）Neurological (Eg.Brain) | | | |
| 呼吸系统 Respiratory (E.g. Asthma) | | | |
| 心脏系统 Heart (Eg. Heart attack) | | | |
| 内分泌系统 Endocrine (E.g. Diabetes) | | | |
| 泌尿系统 Urinary (E.g. UTI) | | | |
| 妇产科 Gynaecology (E.g. Period pain) | | | |
| 肠胃科 Gastrology (E.g. Reflux, IBS) | | | |
| 肌肉骨骼系统 Musculoskeletal (E.g. Osteoarthrisis) | | | |
| 血管系统 Vascular (E.g. DVT) | | | |
| 癌症病史（请注明类型）Cancer, please specify | | | |
| 其他 Others | | | |

| 家族病史 **FAMILY MEDICAL HISTORY:** | 有 **YES** | 无 **NO** | 请注明谁 **PLEASE SPECIFY WHO** |
|---|---|---|---|
| 心脏有关疾病 Heart related, please specify | | | |
| 中风 Stroke | | | |
| 糖尿病 Diabetes, please specify | | | |
| 呼吸系统疾病 Breathing related | | | |
| 血液相关疾病 Bleeding related | | | |
| 癌症病史(请注明类型) Cancer, please specify | | | |
| 精神方面病史 Mental health related, please specify | | | |
| 其他 (请注明) Others, please specify | | | |

**OUR PRIVACY AND MEDICAL INFORMATION**

Complying with The Privacy Act, your consent is required for information collected. This medical practice 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 access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management, in which your consultation may include the presence of a medical student or GP registrar. All information is de-identified. If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all times your health information is treated with utmost confidentiality. **In accordance to medical legislations, doctors and staff in this practice will not discuss test results over the phone and results are only authorized to release by our Doctors.**

OUR COMMUNICATION

By signing this form, you acknowledge that appointment reminders, follow-up reminders and report recalls will be communicated via SMS. This is a courtesy service that we offer, it may not be sent on all occasions and the responsibility for attending appointments, cancelling them and calling for results still rests with you. You reserve the right to cancel the SMS service at any time.

**YOUR RESPONSIBILITIES**

Patients are required to return for a consultation to obtain test results, preferably with the doctor who ordered your tests. If any results are abnormal and/or require urgent attention we will contact you. Please make sure reception has your current phone number and address details when booking or settling your account. It is crucial that you understand that this is your responsibility to ensure you contact and return for your results.

**病人隐私和医疗信息**

为了遵守隐私法，我们需要征得您的同意。本诊所收集您的信息，主要目的是为了提供优质的医疗保健。我们需要您提供您的个人信息和完整的医疗记录，以便我们能够正确诊断，治疗并积极应对您的医疗保健需求。这意味着我们将把这些信息用于管理目的，同时向与您有关的医疗保健人员披露信息;这也包括专科医生和其他治疗团队。本诊所有时可能涉及研究和质量控管活动，以改善个人和社区卫生保健和实践管理。另外，您在本诊所诊病过程中，有可能会有医学生以及全科医生培训医师在场。如果您不希望有其他医护人员了解您的病情，请通知您的诊治医生。我们向您保证，您的健康信息在任何时候都会被严格保密。根据医疗法规，本诊所的医生和工作人员不会通过电话与您讨论检验结果或任何报告，您的任何檢驗報告只有醫生有權限能提供。

**病人聯絡信息**

簽完此同意書，您將同意並瞭解我們會利用短訊功能做預約提醒或報告須回診，你瞭解這是我們提供的額外服務，不能保證隨時都會收到，預約 / 取消預約 / 約診複查報告還是您的責任。隨時取消這項服務是您享有的權益。

**您的责任**

病人需回诊取得任何检验报告结果，与推荐检验的医生咨询为佳。如任何检验报告有异常或需要紧急处理我们将联系您。您在预约或结账时请确保前台有您最新的联络资讯。请注意您有责任联系我们并回诊咨询检验报告。

□ 我已经阅读并了解以上讯息。

I have read and understood the above information regarding my medical information.

**病患/监护人签名**

SIGNATURE OF PATIENT/GUARDIAN: _____ **日期**DATE: / /

FOR STAFF USE ONLY

| DRIVERS LICENSE / PHOTO ID NUMBER: | SIGHTED BY: | DATE: |
|---|---|---|