Sunnybank Plaza
Family Clinic
ABN 40 886 273 925

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.

Please make sure the name written is exactly the same as shown on your Medicare card.

Title	☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Mast. ☐Other ________		
Surname	__________ **Given Name** __________	**D.O.B.**	/ /
Preferred Name	__________ **Marital Status** ______	**Birth Country**	__________
Gender	☐ Male ☐ Female ☐ Others _____	**Occupation**	__________
Ethnicity	☐ Australian, non indigenous ☐ Aboriginal but not Torres Strait Islander ☐ Torres Strait Islander but not aboriginal	☐ Both Aboriginal and Torres Strait Islander ☐ Other, Please specify __________	
Address	__________	**Suburb** ______	**Post code** ______
Home phone	______ **Work phone** ______	**Mobile**	__________
Email			
Medicare Card No.:	__________ **Ref. No.:** ______	**Expiry:**	__________
Pensioner Card No.:	__________	**Expiry:**	__________
Healthcare Card No.:	__________	**Expiry:**	__________
Overseas Student HC:	__________ No. __________		__________
DVA Card No.:		☐ Gold ☐ White ☐ Orange	
Next of Kin	**Given Name** __________	**Surname**	__________
Address	__________		
Contact no.	**Alt. contact no.**	**Relationship**	
Emergency contact	**Given Name** __________	**Surname**	__________
Address	__________		
Contact no.	**Alt. contact no.**	**Relationship**	
Do you drink alcohol?	☐ YES ☐ NO **How many?** ______	Per day ______ Per week	☐ Socially
Do you smoke?	☐ YES ☐ NO **How many?** ______	Per day ☐ Ex Smoker	
Allergies	☐ YES ☐ NO If yes, specify: __________		
Current medications	__________		

How did you hear about our practice?

☐ **Please tick only if you do not want your health summary shared to MyHealth Record services.**

Please note: if you do not want to participate, you need to contact My Health Record Help line: 1800 723 471.

PLEASE TURNOVER TO COMPLETE THE FORM, THANK-YOU

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PAST MEDICAL HISTORY:	YES	NO	PLEASE SPECIFY
Neurological (E.g. Brain)			
Respiratory (E.g. Asthma)			
Heart (E.g. Heart attack)			
Endocrine (E.g. Diabetes)			
Urinary (E.g. UTI)			
Gynaecology (E.g. Period pain)			
Gastroenterology (E.g. Reflux, IBS)			
Musculoskeletal (E.g. Osteoarthritis)			
Vascular (E.g. DVT)			
Cancer, please specify			
Others, please specify			

FAMILY MEDICAL HISTORY:	YES	NO	WHO
Heart related (E.g. Hypertension)			
Stroke			
Diabetes, please specify			
Breathing related			
Bleeding related			
Cancer, please specify			
Mental health related, please specify			
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.

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

SIGNATURE OF PATIENT/GUARDIAN: ________________________ **DATE:** / /

FOR STAFF USE ONLY

DRIVERS LICENCE/PHOTO ID NUMBER: ____________ **SIGHTED BY:** ____________ **DATE:** / /