Patient Registration Form

Welcome to Glenwood Medical Practice. We are committed to providing our patients with quality care. To do this it is essential that your health record is kept up to date and accurate

GLENWOOD MEDICAL PRACTICE

YOUR PERSONAL DETAILS

First name:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other:

Middle name:

Preferred name:

Last name:

Date of birth: ___ ___ / ___ ___ / ____ ____ ____ ____

Gender ID: ☐ Male ☐ Female ☐ Non-Binary ☐ Trans ☐ Gender Diverse

Birth Sex: ☐ Female ☐ Male ☐ Other

YOUR RESIDENTIAL ADDRESS

Street name & no.: | City/Suburb: | P/code:

***YOUR POSTAL ADDRESS** (IF DIFFERENT FROM RESIDENTIAL ADDRESS)*

Street name & no.: | City/Suburb: | P/code:

YOUR CONTACT DETAILS

Mobile: | Work: | Home:

Email:

Would you like to receive clinical reminders via text messaging? ☐ Yes ☐ No

Preferred contact: ☐ Mail ☐ Email

YOUR OCCUPATION

Occupation: ☐ Unemployed ☐ Retired

YOUR RELATION TO HEALTH INITIATIVES – DO YOU IDENTIFY YOURSELF AS ABORIGINAL OR TORRES STRAIT ISLANDER?

☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

If no, what is your cultural background?

YOUR MEDICARE INFORMATION

Medicare No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ | Line No.: | Expiry: ___ ___ / ___ ___ / ___ ___ ___ ___

YOUR PENSION INFORMATION *(IF APPLICABLE)*

Pension/HCC No.: | Ref No.: | Expiry: ___ ___ / ___ ___ / ___ ___ ___ ___

Card type:

DVA No.:

YOUR NEXT OF KIN:

Name: | Relation: | Phone:

YOUR EMERGENCY CONTACT ☐ ***please tick box if same as Next of Kin***

Name: | Relation: | Phone:

YOUR PRIVACY & CONFIDENTIALITY

Glenwood Medical Practice collects information from you for the primary purpose of providing comprehensive quality medical care.
It is important that you do not withhold information that would influence the medical treatment or advice given.
We are committed to patient privacy and confidentiality and will only release information about you to other health professionals involved in your care or when the law requires us to do so.
Please do not hesitate to discuss any concerns or questions about any issues to the privacy of your personal information with your doctor.

By becoming a patient of Glenwood Medical Practice and signing this Patient Registration Form, I agree and consent to the following:

I consent to the use of my personal health information by the Glenwood Medical Practice and other health care providers involved in my medical treatment and health care within this center.
I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.
As part of preventative health services offered by this practice, we send out follow up reminders and recalls when routine investigations are due.
I consent to receive follow up reminders and recalls as necessary.

YOUR SIGNATURE | ***DATE***

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM

YOUR HEALTH HISTORY

Do you consent to Glenwood Medical Practice GPs accessing your 'My Health Record' for the purpose of ongoing medical care?

☐ Yes ☐ No ☐ I have 'Opted Out' for My Health Record

Do you have any allergies or are sensitive to drugs or dressings? ☐ Yes – Please list below ☐ No

Do you or have you ever had any of the following conditions? ☐ **Yes – Please tick below** ☐ **No**

☐ Diabetes	☐ Asthma	☐ Heart Problem	☐ Anxiety
☐ Kidney Disease	☐ Epilepsy	☐ High Blood Pressure	☐ Depression
☐ Colon Cancer	☐ Breast Cancer	☐ Stroke	☐ Other ________________________

YOUR BLOOD GROUP

Do you know your blood group? ☐ Yes, my blood group is ___ ___ ___ ☐ No

FOR YOUR CHILD *(TO BE COMPLETED IF THIS FORM IS FOR YOUR CHILD)*

Is your child up to date with his / her immunisations? ☐ Yes ☐ No

Please provide a copy of your childs most recent immunization history

YOUR RELATION TO TOBACCO

☐ I have never smoked ☐ I smoke ☐ I ceased smoking (please advise date) ___ ___ / ___ ___ / ___ ____ ____ ____

YOUR RELATION TO ALCOHOL

Do you drink alcohol? ☐ Yes ☐ No ☐ Socially

FOR FEMALE PATIENTS

Please provide the date of your last Cervical Screening Test ___ ___ / ___ ___ / ___ ___ ___ ___

REFERRAL SOURCE – How did you hear about this medical practice?

☐ Word of mouth ☐ Drive / walk past ☐ Leaflet / Flyer ☐ Website ☐ Google

OFFICE USE ONLY

Admin **1. PATIENT ID HAS BEEN SIGHTED (**ie. Medicare card or D/L) ☐ INTIALS: __ __ DATE: ____ / ___ / ___

Admin **2. ALL ADMINISTRATIVE INFORMATION HAS BEEN ENTERED** ☐ INTIALS: __ __ DATE: ____ / ___ / ___

Admin **3. ALL CLINICAL INFORAMTION HAS BEEN ENTERED** ☐ INTIALS: __ __ DATE: ____ / ___ / ___

Nurse **4. FORM HAS BEEN SCANNED TO PATIENT FILE** ☐ INTIALS: __ __ DATE: ____ / ___ / ___