Cockburn Medical Centre
Individual, all-round care.

NEW PATIENT REGISTRATION FORM

Please note all information requested on this form is to help provide you with the best medical care.
All information is STRICTLY CONFIDENTIAL and will be safe guarded under our Practice Policy on Privacy.
If you choose not to answer questions that would make it impossible for us to send you accounts, then you will be required to pay before consultation with the doctor.

PATIENT INFORMATION			**Please print letters. Use black or blue pen. Please ☑ all applicable boxes**
Family name As per Medicare		Title	
Given name As per Medicare		Preferred name	
Birth Sex	☐ Male ☐ Female	Date of Birth	
Gender *(if different from birth sex)* ☐ Non-binary ☐ Gender diverse ☐ Transgender ☐ Different Identity		Pronouns	e.g. she/her
Home address		Suburb & Postcode	
Postal Address	☐ Same as above	Suburb & Postcode	
Home phone		I consent to sms reminders, recall and reminder letters to help me maintain my health	☐ Yes ☐ No
Mobile phone			
Work phone			
Email address		I consent to email communication	☐ Yes ☐ No

CULTURAL IDENTITY

To assist with health initiatives do you identify yourself as of Aboriginal and or Torres Strait Islander descent?
☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal & Torres Strait Islander ☐ No

Country of Birth		Ethnic Background	
Do you require an interpreter service? ☐ Yes ☐ No		Home language	

HEALTHCARE IDENTIFIERS - *Please present your Medicare Card and applicable concession cards to reception*

Medicare Number	| | | | | | | | | |	IRN	Exp /
DVA Number - White ☐ Gold ☐ Orange ☐	| | | | | | | |		
Pension ☐ Healthcare ☐ Concession Card Number ☐	| | | | | | | | | |		Exp / /

NEXT OF KIN	**Relationship to patient:**		
Name		Mobile/Home telephone	

EMERGENCY CONTACT	**Relationship to patient:**		
Name		Mobile/Home telephone	

Patient under 12 years of age – Account Payer (leave blank if not applicable)

Full names		Relationship to patient	
Address		Mobile	

Please take a moment to tell us how you heard about us?

P.T.O.
Please see reverse side

Health Information Collection and Use Consent Form

As a patient of our medical practice, we require 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.

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 collection, use and disclosure of your health information.

Please read this consent form carefully, and sign where indicated below.
We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements and for the purpose of debt collection.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside his medical practice and Allied Health Professionals. This may occur through 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, Subpoena, Court Orders)
- For recall and reminder letters/sms which may be sent to you regarding your health care and management.
- For National/State recall and reminder systems (e.g. BreastScreen WA, National Bowel Cancer Screening)
- For My Health Record purposes (please refer to our My Health record policy).

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.

Please tick

• I have read the information above and understand the reasons why my information is collected.	☐
• I understand that I am not obliged to provide any information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.	☐
• I am aware of the rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
• I understand that if my information is to be used for any other purpose set out above, my further consent will be obtained	☐
• I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access of disclosure of which I notify this practice.	☐
• *I shall be liable and pay upon demand any debt collection costs, legal costs, fees and dishonoured cheque fees that are associated with my account.*	☐
• I understand CMC will employ all reasonable means to protect the security and confidentiality of electronic information sent and received. I understand there are known risks that my affect privacy when using electronic methods to communicate. I acknowledge these risks include, but are not limited to: o Email, fax and SMS can be forwarded, printed and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without my knowledge or agreement; o Email may be sent to the wrong address, is easier to forge, and may be intercepted during transmission without detection or authorisation; o Email is not a secure way or corresponding and I have been advised not to transfer any sensitive information in this format.	☐

Patient's Name		Date	
Patient or Parent/Guardian's Signature			

Will you be a permanent patient at this practice? ☐ Yes ☐ No ☐ Unsure

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New Patient Health Information Questionnaire

We are committed to providing our patients with the best care.
To do this, it is essential that your health record is kept up to date and accurate.
ALL patients are asked to complete the following.

PATIENT INFORMATION			**Please print letters. Use black or blue pen. Please ☑ all applicable boxes**
Patient Name		Date of Birth	
Do you have a MHR (My Health Record)? ☐ Yes ☐ No ☐ Unsure			

ALLERGIES / REACTIONS		
Do you have any ALLERGIES or are you sensitive to medications or dressings? ☐ No ☐ Yes (Please list)		
Product	**Reaction**	**Severity**

SOCIAL AND LIFESTYLE HISTORY			
Occupation		Retired	☐ Yes ☐ No
Marital Status	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed		
ALCOHOL ☐ Non-Drinker	☐ Yes How many days per week would you have a standard drink? _____ How many standard drinks containing alcohol would you have on a typical day? _____ PAST ALCOHOL INTAKE ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy. Year Started _____ Year stopped _____		
TOBACCO ☐ I have never smoked	☐ Yes Cigars/Cigarettes per day _____ Pipe tobacco pouches per day _____ or ☐ Stopped smoking YEAR Smoked _____per day/week		

HEALTH HISTORY		
Weight _____ **Kg**	**Height** _____**cm**	**Waist Measurement** _____**cm**
Do you suffer from, affected by, or had any of the following? (Please elaborate)		
☐ Asthma	☐ Diabetes	
☐ Chronic Illness	☐ Hypertension	
☐ Surgery	☐ Other	

SCREENING

Have you had a full body skin check? ☐ Yes ☐ No When:

Female health checks – when last did you have a mammogram / breast exam? Date _____ ☐ Unsure ☐ Never

FAMILY HEALTH HISTORY

Please list any family members who have been diagnosed with, or suffered from: *(please state "mother, father or brother"*

Asthma	☐ Yes e.g. Mother and brother
Breast Cancer	☐ Yes
Cancer – other (state type)	☐ Yes
Colon Cancer	☐ Yes
Depression	☐ Yes
Diabetes	☐ Yes
Heart Disease	☐ Yes
Hypertension	☐ Yes

Please list other family members who currently attend Cockburn Medical Centre or would like to

Name	Date of Birth	Name	Date of Birth