LABRADOR PARK
MEDICAL

'The Science of Medicine...The Art of Caring'

## NEW PATIENT REGISTRATION FORM

Surname: ______________________First Name: _____________________Preferred Name: __________________

Male / Female (Please circle) Title:Mr/Mrs/Ms/Miss/Mstr Date of Birth: _____/______/______

Residential Address: ______________________________________Suburb______________Post Code__________

Postal Address (if different from residential)___________________________________________________________

Home Phone: _____________________ Work: ____________________ Mobile: _______________________

Email Address (**16+ only**): _______________________________ Do you allow SMS reminders for recalls: Yes ☐No ☐

Occupation: _______________________________________ Student: Yes ☐No ☐

Medicare Card Number: _______________________________ Ref: ______ Expiry: _________________

Dept Vet Affairs Card No: _________________________ Expiry: _______/_________ Gold/White (please circle)

If White, conditions covered: __________________________________________________________________

Pension / Health Care Card No: _______________________ Expiry: ____/____ EHealth Registered: Yes / No

Do you identify as: Aboriginal ☐ Torres Strait Islander ☐ Neither: ☐ Refugee ☐

Cultural Background: ________________ Languages Spoken: _________________ Interpreter Required: Yes/No

Next of Kin: ___________________________________ Relationship: ___________________________________

Home Ph: __________________ Work Ph: _____________________ Mobile Ph: _________________________

Emergency Contact: ______________________ Home: _______________ Work: _______________

We'd love to know how you heard about us? Google ☐ Website ☐ Facebook: ☐ Shopping: ☐
Chemist: ☐ Gold Coast Info Pad: ☐ Family / Friends: ☐

Referred by another practice/doctor: ☐ (please advise)..........................................
Other: ☐ (please advise)..........................................

How did you book this appointment?: Online ☐ In Person ☐ Telephone ☐

Your health is important to us, please tick if you would like more information on any of the following services:

Skin Check ☐ Asthma Education ☐ Quit Smoking ☐ Immunisation/Vaccination ☐
45 to 49 year Health Assessment ☐ 75 year + Health Assessment ☐ Diabetes Education ☐

**PLEASE TURN OVER TO COMPLETE THIS FORM**

**Office Staff Only**
**Medicare Sighted – YES / NO Photo ID Sighted – YES / NO Staff Member Initials ...............**

LABRADOR PARK MEDICAL

'The Science of Medicine... The Art of Caring'

**PATIENT INFORMATION CONSENT**

We require your consent to collect personal information about you like your Medicare card number or DVA card number and photo identification document, which will be held on file for identification purposes. Please read this information carefully and print your name and sign where indicated below. This information is used for the primary purpose of providing quality health care services for your health care needs. This practice has a strict policy on handling patient information. To ensure the security of personal information only authorised staff within the practice have access to this information. The information that you provide will only be used for:

- Administrative purposes
- Email purposes – Practice updates and newsletters
- Billing purposes, including compliance with Medicare Australia requirements
- Disclosure to others involved in your care, i.e. Referrals, case conferences, medical tests or results.
- De Identified data provided to external bodies for health improvement purposes.

In other situations, we would not disclose your personal information without your consent.

**Privacy Policy:**
Full copy available on request.

**Restricted Drug Policy:**
Patients requesting prescriptions for drugs MUST adhere to the following guidelines: -

1. Be in a position to have documentary evidence justifying the prescription.
2. Produce further proof of identity in addition to your Medicare card.

All prescriptions for restricted drugs are verified with the following government agencies

1. Medicare Australia
2. Queensland Health Drugs of Dependence Unit.

We use eRX and all our scripts are barcoded.

Any children under the age of 16 years of age must be accompanied by a parent or guardian.

**Please note: Patients who fail to attend booked appointments, without notice (1hr), will be charged a $20 fee for a short appointment, or $40 for a long appointment. No further appointments will be permitted until the outstanding fee is paid.**

I have read this information above and fully understand the content. I consent to the handling of my information by Labrador Park Medical for the purposes set above.

Patients Name: ________________________________Parent/Guardian:_____________________________

Signature: _________________________________________ Date: ____________________________

We are pleased to be able to send seasonal information to keep you up to date with the practice and the services on offer.
Please tick if you ***do not want*** to receive this information from the surgery by email or SMS ☐

LABRADOR PARK
MEDICAL

'The Science of Medicine...The Art of Caring'

## MEDICAL HISTORY FORM

Name: ______________________________________________ Date of Birth: _____/______/______

**Allergies** (Please tick): ☐ Nil Known ☐ Existing (please give details)....................................................................

Reaction & Severity: ..........................................................................................................................................

**Medication**
Are you on any prescribed medication?: Yes ☐ No ☐ If yes, please advise:...........................................................

Over the counter medication/vitamins? Yes ☐ No ☐ If yes, please advise:..........................................................

**Family History**
Has any family member been diagnosed with any chronic disease? Yes ☐ Not Known ☐

If yes, which family member and type of disease: .........................................................................................

**Smoking**
Do you or have you ever smoked? Yes ☐ No ☐ If yes, year started:.................... year stopped: .......................

How many of the following do you smoke per day? Cigarettes .............. Cigars .............. Pipe..........................

**Alcohol Consumption**
How often do you consume alcohol?
Never ☐ Monthly or less ☐ Fortnightly or less ☐ Once a week ☐ 2-3 days p/week ☐ 4+ days p/week ☐
When drinking, the number of standard drinks consumed:
1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+ ☐

**Womens Health**
How long ago was your last pap smear? ..........................How long ago was your last mammogram?.........................

How long ago was your last breast ultrasound? ............................ Results? ........................................................

**Mens Health**
Have you ever had a prostate check? Yes ☐ No ☐ If so, when? ..............................

**Immunisations / Vaccinations**
Please indicate approximate date vaccinated:
Tetanus: ...................... Pneumonia: ......................... Hep A/B: .......................... Chicken Pox: .....................
Shingles: ..................... Influenza ............................ Whooping Cough: .....................

**Mental Health**
Have you ever received medical attention or counselling for psychological or emotional issues?:
Yes ☐ No ☐ Please provide details...........................................................................................................
Have you ever been prescribed medication for psychological or emotional issues?
Yes ☐ No ☐ Please provide details...........................................................................................................

**PLEASE TURN OVER TO COMPLETE THIS FORM**

LABRADOR PARK
**MEDICAL**

'The Science of Medicine...The Art of Caring'

**Past Medical History**

Have you been diagnosed with any of the following? Yes ☐ No ☐ If yes, please circle diagnosis:

Asthma Cancer Diabetes Arthritis Chronic Heart Disease

Have you ever had surgery or been hospitalised? Yes ☐ No ☐

Surgical Procedures / Dates.......................................................................................................................................

.......................................................................................................................................................................

**Other Clinicians: GP / Specialist**

Name: ............................................................................ Speciality: ...............................................................................

Contact Details: ...................................................................................................................................................

Name: ............................................................................ Speciality: ...............................................................................

Contact Details: ...................................................................................................................................................

**Additional details/information that may help with your medical treatment:**

Height: .................................... Weight: .........................................

.......................................................................................................................................................................

Would you like to register with My Health here at this practice and upload your summary? Yes ☐ No ☐

I certify that the information supplied is true and correct to the best of my knowledge.

Signature: ..................................................................... Date: ............/........./...................

Parent/Guardian Name: (if under 16 years)............................................................................................

**Please note:** Undisclosed information, or inaccuracies in the information provided could result in an adverse outcome in relation to your medical treatment.