CLEAR ISLAND WATERS
HEALTH PRECINCT

Patient Registration Form

Section A: **Personal details**

Title: *Mr / Mrs / Miss / Ms / Master/ Other* _____ Surname: _____

Given name/s: _____ Preferred Name: _____

Gender: Male/Female/other _____ **If other gender please state** Date of birth: _____

Address: _____

Suburb: _____ Postcode: _____

Phone Numbers: (**m**) _____ (**h**) _____ (**w**) _____

Email: _____

Medicare Card Number: ☐☐☐☐☐☐☐☐☐☐ Ref No: ☐ Expiry: ☐☐ / ☐☐☐☐

Concession Card/DVA Number: _____ Expiry_____ **Please circle:** DVA Aged Disability Healthcare

Occupation_____

Next of Kin Name: _____ Mobile: _____ Relationship: _____
(first name) (last name)

Emergency Contact Name: _____ Mobile: _____ Relationship: _____
(first name) (last name)

Section B: **Cultural background**

Do you identify as Aboriginal or Torres Strait Islander? ☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both

Preferred language: English/Other _____ Nationality: Australian/Other _____

Section C: **Consent**

I hereby give permission for the Clear Island Waters Health Precinct staff and Doctors to receive and supply personal medical information from or to other medical practitioners/specialists/pathology/radiology etc on my behalf.
I acknowledge that I am responsible for arranging further appointments to discuss test results, conducted by my doctor. I give permission to be notified by letter, phone, email or text message for all recalls and reminders. I give consent to for the Clear Island Waters to access the Cervical Screening and Bowel Screening register - If required.

OFFICE USE

HIC Online, For Eligible Bulk Bill Patients

I hereby authorize Clear Island Waters Health Precinct to process my claim through Medicare Australia

Signed _____ Date _____

Or Signed authority _____ Date _____

ID Verification
Medicare ☐ Photo ID ☐
Staff Member Initial: .....

Please keep this page to give to the Nurse

NAME:_____ DOB: _____

Section D: **Allergies, medications and social statuses**

List allergies and intolerances to medications:

Describe your reaction:

List regular medications and doses, and complementary medicines and doses:

Is there any family history of Diabetes, Heart Disease, Tumours etc.? ☐ **No** ☐ **Yes** **(please give details)**

Condition	Relationship (Mother, Father, etc.)

Smoking status: **Please circle**

	Current smoker	Ex-smoker	Non-smoker
	How many per day?	Year stopped?	
	Year started?		
Please circle	Type: cigarettes, cigars, pipe, vape	Type: cigarettes, cigars, pipe, vape	

Drinking status: **Please circle**

	Drinker	Ex-heavy drinker	Non-drinker
	How many per day/week?	How many standards per day?	
		Year stopped?	

Marital status: **Please circle** Single Married Divorced Widowed De facto Separated

Section E: **Consent to clinical documentation tools**

I understand that my clinician may use secure digital tools to assist in accurate and efficient clinical notetaking. These tools are used solely for clinical care and are compliant with the Privacy Act 1988 (Cth) and Australian Privacy Principles. I consent to the use of such tools for managing my health information.

Name: …… Signature: ……

Date: …… GP name: ……

Disclaimer: We need this information to provide the best quality care. This form complies with the RACGP *Standards for general practices*. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave this form blank and discuss it with your GP.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.