Regency Medical
Health and Care connected

REGENCY MEDICAL CLINIC, RMC
PROSPECT & NORTHFIELD SURGERY

PLEASE COMPLETE ALL DETAILS ON THIS FORM IN FULL

We need this information to provide the best quality care. Your personal health information is kept private and secure as required by Federal and State privacy laws. Please notify us promptly of any changes in your contact details so we can contact you promptly about tests and results.

How did you hear about us? Friend/Family ❒ Website ❒ Online Appointments ❒ Facebook ❒ Messenger ❒ Walk/Drive by ❒ Other: _____

NAME:

(Title) _____ First Name Last Name _____ DATE OF BIRTH: ____/__/____

Male / Female Home Phone (Area Code____)_____ Work Phone _____

Mobile _____ **I would prefer NOT to receive SMS communications** ☐

Home Email Address: _____ **I would prefer NOT to receive Emails** ☐

Home Address: _____ Post Code_____

Postal Address: *(if different to above)* _____ Post Code_____

Medicare No: _____ (Patient Reference # ____) Expiry Date: ____/____/____

Pension/Health Care Card *(please circle)* # _____ Expiry Date: ____/____/____

Veteran's Affairs_____ (Gold or White) card Expiry Date: ____/____/____

EMERGENCY CONTACT **NEXT OF KIN** (☐ tick if same as emergency contact)

NAME: _____ NAME:_____

Contact Phone #: _____ Contact Phone #:_____

DO YOU WISH TO IDENTIFY YOUR CULTURAL BACKGROUND?

No ❒ Aboriginal ❒ Torres Strait Islander ❒ Both (ATSI) ❒ Other ❒ *(specify)*: _____

Interpreter Required: No ❒ Yes ❒ Languages Spoken: _____ Country of Birth: _____

IF PATIENT UNDER 16 YEARS OF AGE:

Parent's Name:_____ **Parent's** Date of Birth: ____/____/____

Parent's Medicare number (*if different to child*) _____ (Patient Reference # ____) Expiry Date: __/__/_

LEGAL GUARDIAN

Guardian Board ❒ Other ❒ Specify: _____

Guardian's Name:_____ Date of Birth: ____/____/____ Phone: _____

Home Address: _____ Post Code: _____

I acknowledge that I am responsible for payment of all accounts.

PATIENT SIGNATURE: _____ Date_____/_____/_____

REGENCY MEDICAL CLINIC
PATIENT MEDICAL INFORMATION

C O N F I D E N T I A L - PLEASE GIVE THIS SECTION TO YOUR DOCTOR ONLY

Name:	**Date of Birth:**

Marital Status Single ☐ Married ☐ De-facto ☐ Divorced ☐ Separated ☐ Widowed ☐

Occupation:

ALLERGIES **No (none known)** ☐ **Yes** ☐ (Please list below and include any known reactions):

_____

_____

ANY SIGNIFICANT MEDICAL PROBLEMS IN THE FAMILY? (i.e. grandparent, parent, sibling)

Cancers ☐ Heart Disease ☐ Asthma/Airway Disease ☐ Inherited Medical Conditions ☐ Other: _____

Please specify details:

_____

_____

Smoking Status:

Non-Smoker ☐ Smoker ☐ Ex-Smoker ☐ Year Quit _____

If smoker, how many years (approximately) have you smoked for? _____

What sized packs do you buy? 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 50 ☐ Pouch ☐

How many packs do you buy per week? _____

Alcohol Consumption:

Nil ☐ Less than once per week ☐ 2-3 days/week ☐ 4-6 days/week ☐ Daily ☐

Number of usual drinks consumed (standard drinks) 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-10 ☐ More than 10 ☐

Any other drugs used? Marijuana ☐ Speed ☐ Ecstasy ☐ Heroin ☐ Cocaine ☐

Other ☐ How often?

Medications (include over the counter, herbal and contraceptive medications):

_____

_____

Medical Problems: Current:

_____

_____

Medical Problems: Past

_____

_____

Surgical History:

_____

_____

Please use following page to provide any further information

Further Information:					
NURSE USE ONLY:					
BP	/	Pulse	bpm	SaO_2	%
Height:	cm	Weight	kg	BMI	

NOTE: This is NOT a Bulk Billing Practice

We are a private practice and require full payment at the time of consultation. You can do this by cash, Eftpos, credit card or cheque. You can receive your Medicare rebate instantly. If payment in full is an issue for you, please discuss with the GP at the time of your consult.

Medical care requires full knowledge of patient health information by all members of a medical team. To ensure quality and continuity of patient care a patient's information has to be shared with other health care providers from time to time. I provide my consent for the doctors of Regency Medical Clinic/Northfield Surgery to collect, use and disclose my information for the quality and continuity of my health care, recalls and other preventative health activities. I understand that I may withdraw my consent as to the use and disclosure of my personal information (except when legal obligations must be met).

Privacy Policy – Keeping your personal information private

It is the policy of this practice to maintain the security and confidentiality of personal health information at all times. Your health information is only available to authorised members of staff. Our practice collects and safeguards the confidentiality and privacy of health information and complies with the Australian Privacy Principles.

Collection:
- We collect only the information necessary to deliver the service;
- We collect information lawfully, fairly and non-intrusively; and
- We obtain a person's consent to collect health information about them.

Use of information:
- We use this information for the main reason it was collected, that is to provide patients with comprehensive health care services, including diagnosis and treatment of health problems, which may include communicating with practice staff, specialists and other health care providers involved in a patient's care; and
- Health care prevention activities including recall and reminder systems; and
- Accreditation and Quality Assurance; and
- Billing and collection of professional fees; and
- For work-related or medico-legal reasons; and
- Teaching and research; or
- for directly-related secondary purposes, reasonably expected by the patient; or with consent of the patient.

Data Quality:
- We take all reasonable steps to ensure health records are kept up-to-date, accurate and complete.

Data Security:
- Our electronic information is protected by Firewall, Virus protection and passwords.
- Individual Health Identifiers are utilised and stored in clinical software which is password protected.
- We do not disclose personal information to overseas recipients unless you request us to do so.
- We take all reasonable steps to protect and secure health information from loss, misuse and unauthorised access.

Access & Correction
- Patients have a general right of access to their own health records and correct any inaccuracies. Written requests to access personal information should be directed to the patient's usual GP.

Complaints & Further Information:
- Further information or complaints about breaches of privacy can be made to the Office of the Australian Information Commissioner (OAIC) http://www.oaic.gov.au/privacy. Patients have the right to request a copy of this policy at no charge.

I have been offered a copy of "Keeping your personal information private in our practice" brochure. I understand any concerns I have regarding my privacy can be addressed to the Business Manager or the Office of the Australian Information Commissioner 1300 363 992.

PATIENT SIGNATURE: _____ Date_____/_____/