Regency Medical
Health and Care connected

**REGENCY MEDICAL CLINIC & RMC PROSPECT**

# 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: _____/_____/_____

**NEXT OF KIN** **EMERGENCY CONTACT** (☐ tick if same as next of kin)

NAME: ______________________________ NAME: ______________________________

Contact Phone #: ______________________________ Contact Phone #: ______________________________

## DO YOU WISH TO IDENTIFY YOUR CULTURAL BACKGROUND?

Aboriginal ❐ Torres Strait Islander ❐ Both (ATSI) ❐ Neither ❐ 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_____/_____/