inclusive health clinic
OVERCOMING HEALTH INEQUALITY

Patient Registration form

Title (please circle)	Mr Ms Mrs Miss Other		
Surname			
First Name			
Middle Name			
Preferred Name			
Date of Birth	____ / ____ / ____		
Gender			
Are you Australian Aboriginal or Torres Strait Islander? (Please circle appropriate Response)	**YES** – Aboriginal	**YES** – Both Aboriginal and Torres Strait Islander	
	YES - Torres Strait Islander	**NO** – Neither Aboriginal and Torres Strait Islander	
Home Address			
Postal Address (if different to home address)			
Occupation			
Phone Contact	Mobile:	Home/Other	
Email			
Medicare Number		Ref No:	Expiry Date
Pension card	Number:		Expiry Date
Health care card	Number:		Expiry Date
DVA Gold / White			Expiry Date

Do you consent to receiving SMS communications from the Clinic?
SMS may include appt reminders, clinical communications (results and clinical messages) and health awareness communications: (Please circle appropriate response) **YES** **NO**

Ph 3013 6050 | Fax 3013 6059
Shop 2, 15 Hope Street, South Brisbane Q 4101
PO Box 3449, South Brisbane Q 4101
admin@inclusivehealth.org.au
inclusivehealth.org.au

Inclusive Health Partnerships is committed to ensuring that every person, regardless of their circumstances, has access to quality physical, dental, mental health and holistic healthcare services irrespective of their ability to pay.

Funded by
Queensland Government

Do you have any allergies? (Please circle) YES NO	If you circled YES - What are you allergic to and what is the nature of the reaction?
Next of Kin Relationship to Patient	(Name and Telephone number)
Emergency Contact (If different to Next of Kin)	(Name and Telephone number of a person we can contact if needed)
Nationality / Place of Birth and Language spoken at home (if not English)	
If English is not your first Language Do you require an interpreter?	YES (what Language?) ___________________________ NO

Medical Information

Patient's name.. DOB: ___ / ___ / ______

Family history

When answering the following questions:
Please think about your parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews and grandchildren.

	QUESTION	YES	NO
1.	Have any of your close relatives had heart disease before 60 years of age? Heart disease includes cardiovascular disease, heart attack, angina and bypass surgery.		
2.	Have any of your close relatives had diabetes? Diabetes is also known as type 2 diabetes or non-insulin dependent diabetes.		
3.	Do you have any close relatives who has melanoma?		
4.	Have any of your close relatives had bowel cancer?		
5.	Have any of your close male relatives had prostate cancer before 60 years of age?		
6.	Have any of your close relatives had breast cancer?		
7.	Is there a history of mood disorder in your immediate family?		
	If there is a family history of cancer, Please specify what kind:		

Lifestyle health history (specify approximate month/year

Smoking history:

Never Smoked
Former smoker, quit date ___ / ___ / ______
Current smoker ………. / day
Number of years smoking…………………………

Alcohol:

Do you drink alcohol? Yes No
Drinks per day ……………
Drinks per week ……………

Women's Health History

Last pap smear date ____ / ____ / ______

Last mammogram date ____ / ____ / ______

Men's Health History

Last prostate check (if aged over 40)

Please tick any relevant past medical/surgical history

Heart Disease
High Blood Pressure
High Cholesterol
Diabetes

Cancer
Migraine
Stroke
Blood clots

Asthma
Stomach or duodenal ulcer
Epilepsy
Depression/Anxiety

Other illness/surgery – please give details.

Please list current medications, including vitamins and mineral supplements

Name	Dose	Name	Dose

Patient consent form

So that we may properly assess, diagnose, treat and be proactive in your health care needs we require you to provide us with your personal details and a full medical history.

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 the collection, use, and disclosure of your health information.

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.

- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though 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, allied health providers, locums etc. attached to the practice for the purpose of patient care and teaching.
- For internal 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.
- For reminder letters which may be sent to you regarding your health care and management. Please read this consent form carefully, and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above and it will not affect the care that you receive at this practice.

	Yes	**No**
I have read the information above and understand the reasons why my information must be collected.	☐	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐	☐
I am aware of my 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 other than set out above, my further consent will be obtained.	☐	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐	☐
I understand that the Clinic has expected standards of behaviour and that any aggressive, threatening, violent or abusive behaviours will not be tolerated.	☐	☐

OR

I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐	☐

Patient’s name: .... **Date:** ....

Patient’s signature: ....

Please return the completed form to Reception.