Patient Registration Form

Medical Services

DPV Health

SECTION A – PERSONAL DETAILS

Title: **Mr | Mrs | Ms | Miss | Mast. | Dr** Surname: First Name:

Preferred Name: Date of Birth: Gender: **Male | Female | Other**

Marital status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Address:

Suburb: State: Postcode:

Home Phone: Mobile: Work:

Email:

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ Patient Number on Card: __ Expiry: __ __ / __ __ __ __

Pension Card Number: _____ Expiry: ___ / ___ / _____

Healthcare Card Number: _____ Expiry: ___ / ___ / _____

DVA Number: _____ Colour: Gold / White Conditions: Expiry: __ __ / __ __ __ __

Do you consent to SMS/Email Reminders: ☐ **Yes** ☐ **No**

SECTION B – IDENTITY & CULTURAL BACKGROUND

Knowing your identity and cultural background can help us provide healthcare that meets your individual needs.
If you would like to tell us more about your identity this information will be kept safe and private.

Are you of Aboriginal or Torres Strait Islander origin: ☐ **No** ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal/Torres Strait Islander**

If you do identify as Aboriginal/Torres Strait Islander are you registered with the Close the Gap Program? ☐ **Yes** ☐ **No**

Other cultural background (e.g. Asian, Mediterranean, African): _____

Country of Birth: ☐ Australia ☐ Other: _____

Do you have a refugee background or are applying to become a refugee? ☐ **No** ☐ **Refugee** ☐ **Seeking Asylum**

Is English your first language? ☐ **Yes** ☐ **No**

Do you need an interpreter? ☐ **No** ☐ **Yes,** Language: _____

Optional:

Sexual Orientation: _____

What are your pronouns? ☐ She/Her ☐ He/His ☐ They/Them ☐ Other: _____

Do you have an intersex variation? ☐ Yes ☐ No

SECTION C – IN CASE OF EMERGENCY

Next of Kin Name: Relationship to patient:

Contact Number: Alternate Contact:

Emergency Contact Name: Relationship to patient:

Contact Number: Alternate Contact:

SECTION D – ALLERGIES & MEDICINE

Do you have any allergies, intolerances, or sensitivities? ☐ No ☐ Yes

If yes, please list, state what and your reaction:

List any regular medication you are taking and their dosage (include complementary medicine such as vitamins):

SECTION E – YOUR MEDICAL HISTORY

Do you have, or have you had a history of the following:

☐ Asthma

☐ Autism Spectrum Disorder – Please specify? _____

☐ Chronic Kidney Disease or Renal Failure

☐ Diabetes – Please specify? _____

☐ High Blood Pressure

☐ Heart Condition / Stroke – Please specify? _____

☐ Mental Illness – Please specify? _____

☐ Other – Please specify? _____

Family History

Have any of your family members ever been diagnosed with or suffered from any of the following conditions?

☐ Asthma – Details _____

☐ Diabetes – Details _____

☐ Heart Disease – Details _____

☐ Mental Illness – Details _____

☐ Cancer – Details _____

☐ Other – Details _____

SECTION E – YOUR MEDICAL HISTORY CONTINUED

Social History

Smoking status

Have you ever smoked? ☐ No ☐ Yes - How many per day? _____

If you have or do smoke, what year did you start? _____

If you have ceased or currently ceasing, when did you do this? _____

Nutrition status

How would you rate your current nutrition out of 1 – 10? _____

Alcohol Consumption

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4+ times a week

How many standard drinks containing alcohol do you consume on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Are you currently taking any illicit substances? If Yes, please specify _____

Physical Activity Status **– How often do you currently engage in physical activity for 30 minutes or greater?**

☐ Daily or _____ times per week ☐ Never ☐ Other, please specify _____

Females **– when did you last have the following?**

☐ Pap Smear/Cervical Screening?	Estimated Year? _____	☐ Not sure	☐ Never
☐ Breast Check?	Estimated Year? _____	☐ Not Sure	☐ Never
☐ Mammogram?	Estimated Year? _____	☐ Not Sure	☐ Never
☐ National Bowel Screening?	Estimated Year? _____	☐ Not Sure	☐ Never

Males **– when did you last have the following?**

☐ National Bowel Screening?	Estimated Year? _____	☐ Not Sure	☐ Never
☐ Overall Check-up?	Estimated Year? _____	☐ Not sure	☐ Never

SECTION F – HOW DID YOU FIND OUT ABOUT US?

☐ Friend / Family ☐ Newspaper ☐ Radio ☐ Flyer in letterbox ☐ Driving past

☐ Social Media ☐ Google ☐ Other: _____

HEALTH INFORMATION COLLECTION AND USE – CONSENT FORM

As a patient of DPV Health Medical Clinics we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We only collect personal information that we need to facilitate the provision of medical services and require your consent to collect this information and use it for the purposes stated.

DPV Health is committed to protecting your individual rights to privacy by complying with all relevant legislation relating to the protection of personal information, sensitive information, and personal health records obtained during the course of your care with us. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

DPV Health follows the guidelines of the Royal Australian College of General Practitioners Handbook for the management of health information in private medical practices. This means that your personal health information is kept private and secure, as required by federal and state privacy laws. If you have any concerns regarding the collection and use of your personal information, please speak with one of our team members.

DPV Health uses an automated system to contact patients in specific circumstances, do you consent to receiving:

SMS appointment reminders Y / N

Reminders that clinical appointments are due (such as care plans) Y / N

Clinical communication, such as results or clinical updates Y / N

Health awareness messages that are relevant to you Y / N

DPV Health reviews patient files to facilitate quality improvement and improve patient care. The team members accessing records have signed confidentiality agreements and information is not shared with any external parties.
Do you consent to your records being viewed for this purpose? Y / N

DPV Health undertakes routine surveys to monitor the quality of the services we provide. Do you consent to being sent surveys for this purpose? Y / N

- **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.**

_____ Date: _____ / _____ / _____

Signature

_____ _____

Signature of Guardian Guardian Name