# Patient Registration Form
## Reservoir Medical Group

**PATIENT INFORMATION** (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other___

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Gender; ☐ Female ☐ Male Date of Birth____/____/____

Aboriginal ☐ Yes ☐ No Torres Strait Islander ☐ Yes ☐ No

Country of Birth /Ethnicity_____

Phone Numbers ;

Home_____ Work_____

Mobile_____

Address_____

Suburb_____ Postcode_____ State_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Next of Kin Contact Name_____ Phone Number_____

Relationship to Patient_____

Emergency Contact Name_____ Phone Number_____

**RESPONSIBLE PARTY INFORMATION** ☐ ☐

Person Responsible for Account (Last)_____ (First)_____ (Middle)_

Legal Medical Power of Attorney_____ Phone Number;_____

Legal Power of Attorney_____ Phone Number_____

Power of Attorney Documents Sighted; ☐ Yes ☐ No

**MEDICARE/ INSURANCE INFORMATION**

Medicare Number _____/___ Expiry Date; _____/_____/_____

Pensioner Health Benefits Card Number;_____ Expiry Date; _____/_____/____

Health Care Card Number _____ Expiry Date; _____/_____/____

Dept of Veteran Affairs Number_____ ☐ Gold ☐ White

Other (specify eg TAC)_____ Claim Number (if known) _____

None of the above ☐ Not Sure ☐

Do you have private health insurance? ☐ Yes ☐ No Name of insurer; _____

**HEALTH INFORMATION**

Smoker ☐ Yes ☐ Never ☐ Ex Number per day _____ Alcohol ☐ Yes ☐ Never ☐ Social Number per day_____

Medical Conditions;

High Blood Pressure ☐ Yes ☐ No Arthritis ☐ Yes ☐ No Asthma ☐ Yes ☐ No

Depression ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Cardiovascular ☐ Yes ☐ No Other (specify) _____

Family History eg; diabetes,cancer, heart attacks; _____

Allergies ☐ Yes ☐ No If yes please state what you are allergic to. _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

***Patient (or Responsible Party) Signature***_____ ***Date***_____

***Including permission to use database informationas per next page***

**Patient Registration Form**
**Reservoir Medical Group**

Reservoir Medical Group requires your consent to collect personal information about you. Please read this consent form carefully and tick the applicable boxes where indicated below.

Reservoir Medical Group collects information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health needs. Consent can be withdrawn at any one time either by verbal or written notification. Please place a tick in the following boxes if you consent for this information to be used by Reservoir Medical Group in the following ways:

☑ I give permission for my personal health information to be used for administrative purposes to assist in the running of Reservoir Medical Group, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside Reservoir medical group. This may occur through referrals to other doctors , medical tests or recalls for medical management within Reservoir Medical Group.

☑ I give consent for disclosure for DE-IDENTIFIED personal information for research and quality assurance activities to improve individual, community health care and practice management. This may occur when Reservoir Medical Group incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable information cannot be traced back to the individual.

☑ I give my consent for my personal health records to be used for DE-IDENTIFIABLE patient health information. This may occur when Reservoir Medical Group participates in research activities on behalf of a university as part of professional development activities to be collected. . De-identifiable information cannot be traced back to the individual. If identifiable information is required, I understand that Reservoir Medical Group will contact me prior to its use.

☑ I may give my consent, if required, to the presence of a third party to be present during my consultation. This may include a practice nurse or medical student. I understand that I may retract my consent on an individual basis.

☑ I give my consent to be part of the Practice's national, State and Territory recall and reminder systems. Eg PAP, Mammograms

☑ I give my consent for my next of kin, if nominated, to be contacted in an emergency

☑ I give my consent for Reservoir Medical Group to handover personal information to another practitioner within the clinic during periods where my normal treating doctor is absent in order to manage follow up care.

**Please cross out ticks for those above that you do not give your consent to.**

**For non-english speaking patients:**

I (name)_____ translated the above information to (name of patient) _____ and they have signed on the front of this sheet.
(Name of patient) _____ understands that Reservoir Medical group is authorized on their behalf to use relevant personal information and that they are free to withdraw their consent at any one time by verbal or written notification.