Lagoon Medical Centre
New Patient Registration Form

LAGOON MEDICAL CENTRE

Proudly AGPAL Accredited
Our commitment to your safety and care

Personal Details			**Office Use Only: Photo ID Checked ☐**
Title (*Please circle)* Mr Mrs Ms Miss Mast Other: _____ **Birth Sex** *(circle)* Male/Female **Gender Identity** *(circle)* Male/Female/Non-Binary/Gender Diverse/Different Identity			
Surname (as on Medicare Card)		**Date of Birth:**	
First Name		**Middle Name**	
Street Address (include suburb)			
Home Phone		**Mobile Phone**	
Would you like to be contacted via SMS for appointment reminders, recall and other test reminders? ☐ Yes ☐ No			
Email address		**Occupation**	

Health Care Details			
Medicare Number		**Issue number:** (number next to your name)	**Expiry Date:**
D.V.A Gold / White (please circle)			
Health Care Card (Green)	**Number:**		Expiry Date:
Pension Card (Blue/Red)	**Number:**		Expiry Date:

Emergency Contact Details *(Best person for us to contact on your behalf in the case of an emergency)*		
Next of Kin (Name):	Contact Number:	**Relationship to you:**
Emergency Contact (Name):	Contact Number:	**Relationship to you:**

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds please complete this section.	
Country of Birth:	
Do you require a translator? ☐ Yes ☐ No	**Ethnicity:**
To assist with health initiatives – Are you Aboriginal or Torres Strait Islander? (please tick) ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ No	

I understand that Lagoon Medical Centre complies with the Privacy Act (1988) and Privacy Amendment Act (2000) and as part of their Privacy Policy they are committed to protecting the privacy of the personal information of individuals. The purpose of collecting my personal details is to provide quality medical and health services and related account keeping. I understand that I have the right to request access to my information. Lagoon Medical Centre makes every effort to keep my data in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent to Lagoon Medical Centre to use and disclose my personal information (except where legal obligations are met). **Collection, Use and Disclosure:** We recognise that the information we collect is often of a highly sensitive nature and as an organisation have adopted the highest privacy compliance standards relevant to ensure personal information is protected. We are a service to the medical practitioners who provide services at our practice. For administrative and billing purposes, and to enable the patient to be attended by other practitioners at our practice, patient information is shared between practitioners who attend a patient. We (on behalf of) and the practitioners may collect personal information collected will generally include patient name, address, phone number, Medicare, current drugs and treatments used by the patient, previous and current medical history, including where clinically relevant family medical history, name of any health service provider or specialist to whom the patient is referred, copies of any letters of referrals and copies of any reports back.

Lagoon Medical Centre will be collecting, using, storing and disposing of my personal information, the release of relevant personal information to other health professionals to allow quality medical care (e.g. specialists, pathologists, usual GP, some fees may be incurred for transfer of records, to have my records reviewed by accreditation surveyors as part of this practices accreditation process should my records be randomly chosen for quality assurance, training, billing, liaising with government offices regarding Medicare entitlements and payments and as may be required by our insurers.
We may access information: Provided by the patient, provided on a patient's behalf with the patients consent, from a health service provider who refers the patient to medical practitioners, from health service providers to whom patients are referred. Other than as described in the Policy or permitted under

By signing below, I the patient (or patient/legal guardian) have read and consent to the above and acknowledge that personal information collected by us may be used or disclosed

Signature _____ Date _____/_____/_____

Printed Name: _____ (If the patient is under 16 years the parent/guardian is to sign)

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Surname: _____ First Name: _____ Date of Birth: _____/_____/_____

Please complete and take this section to your doctor

How did you find out about our surgery?

- ☐ **Family/Friend Referral**
- ☐ **Word of Mouth**
- ☐ **Google Search**
- ☐ **Facebook/Instagram**
- ☐ **Flyer**
- ☐ **Local Resident**
- ☐ **Website**
- ☐ **HotDoc (Online Booking)**
- ☐ **Other:** _____

Current Medications
Do you have any allergies or are you sensitive to drugs or dressings? ☐ Yes ☐ Nil Known
If yes, please specify:

. **Your Health History:** (Please tick if applicable)			
	Operations (Give details)		Hypertension
	Diabetes		Asthma
	Cancer		Other (Give details)

Family History: (Please tick where applicable)			
Mother	Still alive ☐ Yes ☐ No ☐ Heart Problems ☐ Cancer ☐ High Blood Pressure ☐ Migraine ☐ Diabetes ☐ Stroke ☐ Asthma ☐ Blood Clots ☐ Depression/Anxiety ☐ Other: _____	**Father**	Still alive ☐ Yes ☐ No ☐ Heart Problems ☐ Cancer ☐ High Blood Pressure ☐ Migraine ☐ Diabetes ☐ Stroke ☐ Asthma ☐ Blood Clots ☐ Depression/Anxiety ☐ Other: _____

Social History	
Do you smoke? ☐ Yes _____/day ☐ No Past smoking history: ☐ Nil ☐ Light ☐ Moderate ☐ Heavy Which year did you stop smoking? _____	Do you drink alcohol? ☐ Yes _____/day ☐ No Past drinking history: ☐ Nil ☐ Light ☐ Moderate ☐ Heavy Which year did you stop drinking? _____
Females: When did you last have? Pap smear: Date: _____ ☐ Not sure ☐ Never Breast Check: Date: _____ ☐ Not sure ☐Never	**Males: When did you last have?** Prostate check (aged over 40) Date: _____ ☐ Not sure ☐ Never