THMP
THE HEIGHTS MEDICAL PRACTICE

HAIM
HUNTER ACUTE INJURY MANAGEMENT UNIT

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New Patient Registration

Title: ❑ Mr ❑ Mrs ❑ Ms ❑ Miss ❑ Mast ❑ Dr ❑ Other_____

Surname: _____ **Given Name**: _____

Middle Name: _____ Preferred Name: _____

Date of Birth: _____

Birth sex: ❑ Female ❑ Male ❑ Other

Gender Identity: ❑ Female ❑ Male ❑ Non-binary ❑ Gender Diverse ❑ Transgender ❑ Different

Preferred Pronouns: ❑ she/her/hers ❑ he/him/his ❑ they/them/theirs

Cultural background:

❑ Aboriginal ❑ Torres Strait Islander ❑ Aboriginal & Torres Strait Islander ❑ Non-Indigenous

Country of birth: _____

Preferred language: _____ Do you require an interpreter service? ❑ Yes ❑ No

Occupation: _____

Address: _____

Suburb: _____ Post code: _____

Postal Address (if different): _____

Home Phone: _____ Work: _____

Mobile: _____ Email: _____

Medicare Number: _____ IRN: _____ Expiry: _____

Healthcare Card Number: _____ Expiry: _____

Pension Card Number: _____ Expiry: _____

DVA Card: _____ Expiry: _____ Type: ❑ Gold ❑ White – Conditions _____

Private Health Insurance Company Name: _____

Member Number: _____

Next of Kin Details:

Name: _____ Contact Number: _____

Relationship to patient: _____

Emergency Contact Details:

Same as Next of Kin: ❑ Yes ❑ No

If no, Name: _____ Contact Number: _____

Relationship to patient: _____

Medical History

Do you have any allergies or are you sensitive to medications or dressings? ❑ Yes ❑ No
Specify? _____ Reaction? _____
_____ _____

Current Medications *(including over the counter medication, vitamins & minerals)*

Name of medication	Strength	Times taken

History

	Year Began	*Active now✓*		*Year Began*	*Active now✓*
Heart Problems			Serious infection		
Angina			Skin rashes, dermatitis, eczema, psoriasis		
High blood pressure			Epilepsy/fits/blackouts/strokes		
High cholesterol			Migraine		
Varicose veins, clots or blocked arteries			Asthma/emphysema		
Stomach ulcers			Hay fever/ sinus problems		
Gall stones			Eye/ ear problems		
Liver disease, Jaundice, Hepatitis			Back/neck problems		
Pancreatitis			Serious trauma		
Hernia/ bowel problems			Emotional disorder/ stress		
Rectal bleeding			Kidney / urine/ bladder problems		
Diabetes			Prostrate problems/ impotence		
Thyroid problem			Abnormal pap smear		
Gout			Sexually transmitted disease		
Arthritis/Joint problems			AIDS		
Cancer-where?			Intravenous drug use		

Reminders & Clinical Communications:

Are you happy for us to send you **Appointment Reminders** via SMS or Email (as given above)? ❑ Yes ❑ No

Are you happy for us to send you **Clinical Communications** via SMS or Email (as given above)? ❑ Yes ❑ No

*This may include Results Follow-up, Health Check Reminders or other relevant Clinical Information

Preventative Health

When was your last check for the following?	Year		Year
Cholesterol		Bowel Screening	
Blood Pressure		HIV Test	
Prostate Check		Hepatitis Test	
Cervical Screening		Skin Check	

Family History

Has anyone related to you ever had?	Relationship to you	Ever had ✓	Age of onset	Died from ✓	Age
High blood pressure					
High cholesterol					
Heart attack/angina					
Stroke					
Anaemia					
Bleeding disorder					
Asthma /emphysema					
Tuberculosis					
Arthritis					
Diabetes					
Kidney disease					
Cancer or tumor					
Other					

Social

	YES	NO	If yes, how often?
❖ Cigarettes	❑	❑	_____ per day
❖ Alcohol	❑	❑	_____ per week
❖ Intravenous drugs	❑	❑	_____
❖ Other Drugs (marijuana)	❑	❑	_____
❖ Exercise	❑	❑	_____

Previous GP Name: _____ Phone no: _____

Previous GP Address: _____

HEALTH INFORMATION COLLECTION AND USE CONSENT FORM

As a patient of our medical practice 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 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. Please read this consent form carefully, and sign where indicated below.

- 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, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and 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.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

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

Patients Name _____ Date_____/_____/_____

Patient's signature _____

Guardian Details

Childs Name (Please print) _____

Guardians Full Name (Please print) _____

Guardians Signature _____ Date _____/ _____ / _____