REDBANK PLAZA
MEDICAL

"The Science of Medicine... The Art of Caring"

NEW PATIENT REGISTRATION FORM

Surname: _____ First Name: _____ Preferred Name: _____

Male / Female (Please circle) Title:Mr/Mrs/Ms/Miss/Mstr Date of Birth: ____/____/____

Residential Address: _____ Suburb_____ Post Code_____

Postal Address (if different from residential)_____

Home Phone: _____ Work: _____ Mobile: _____

Email Address (16+ only): _____ Do you allow SMS for reminders/recalls: Yes ☐No ☐

Occupation: _____ Student: Yes ☐No ☐

Medicare Card Number: _____ Ref: _____ Expiry: _____

Dept Vet Affairs Card No: _____ Expiry: _____/_____ Gold/White (please circle)

If White, conditions covered: _____

Pension / Health Care Card No: _____ Expiry: ____/____ EHealth Registered: Yes / No

Do you identify as: Aboriginal ☐ Torres Strait Islander ☐ Neither: ☐ Refugee ☐

Cultural Background: _____ Languages Spoken: _____ Interpreter Required: Yes/No

Next of Kin: _____ Relationship: _____

Home Ph: _____ Work Ph: _____ Mobile Ph: _____

Emergency Contact: _____ Home: _____ Work: _____

We'd love to know how you heard about us? Online ☐ Website ☐ Letterbox Drop ☐ Facebook: ☐
Shopping: ☐ Chemist: ☐ Email: ☐ Family / Friends: ☐ White Pages: ☐ Yellow Pages ☐
Google: ☐ Health Engine: ☐ Local Newspaper: ☐ Other: ☐ (please advise).....

How did you book this appointment?: Online ☐ In Person ☐ Telephone ☐

Your health is important to us, please tick if you would like more information on any of the following services:

Skin Check ☐ Asthma Education ☐ Quit Smoking ☐ Immunisation/Vaccination ☐
45 to 49 year Health Assessment ☐ 75 year + Health Assessment ☐ Diabetes Education ☐

PLEASE TURN OVER TO COMPLETE THIS FORM

Office Staff Only
Medicare Sighted – YES / NO Photo ID Sighted – YES / NO Staff Member Initials .....

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PATIENT INFORMATION CONSENT

We require your consent to collect personal information about you. Please read this information carefully and print your name and sign where indicated below. This information is used for the primary purpose of providing quality health care services for your health care needs. This practice has a strict policy on handling patient information. To ensure the security of personal information only authorised staff within the practice has access to this information. The information that you provide will only be used for:

- Administrative purposes
- Email purposes – Practice updates and newsletters
- Billing purposes, including compliance with Medicare Australia requirements
- Disclosure to others involved in your care, i.e. Referrals, case conferences, medical tests or results.
- DE identified data provided to external bodies for health improvement purposes.

In other situations we would not disclose your personal information without your consent.

Privacy Policy:
Full copy available on request.

Restricted Drug Policy:
Patients requesting prescriptions for drugs MUST adhere to the following guidelines: -

1. Be in a position to have documentary evidence justifying the prescription.
2. Produce further proof of identity in addition to your Medicare card.

All prescriptions for restricted drugs are verified with the following government agencies

1. Medicare Australia
2. Queensland Health Drugs of Dependence Unit.

We use Medisecure and all our scripts are barcoded.

Any children under the age of 16 years of age must be accompanied by a parent or guardian.

I have read this information above and fully understand the content. I consent to the handling of my information by Redbank Plaza Medical for the purposes set above.

Patients Name: _____ Parent/Guardian: _____

Signature: _____ Date: _____

Please note: Patients who fail to attend booked appointments, without notice (1hr), will be charged a $10 fee for a short appointment, or $20 for a long appointment.
No further appointments will be permitted until the outstanding fee is paid.

We are pleased to be able to send seasonal information to keep you up to date with the practice and the services on offer
Please tick if you ***do not want*** to receive this information from the surgery by email or SMS ☐

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MEDICAL HISTORY FORM

Name: _____ Date of Birth: ____/____/____

Allergies (Please tick): ☐ Nil Known ☐ Existing (please give details).....

Reaction & Severity: .....

Medication

Are you on any prescribed medication?: Yes ☐ No ☐ If yes, please advise:.....

Over the counter medication/vitamins? Yes ☐ No ☐ If yes, please advise:.....

Family History

Has any family member been diagnosed with any chronic disease? Yes ☐ Not Known ☐

If yes, which family member and type of disease: .....

Smoking

Do you or have you ever smoked? Yes ☐ No ☐ If yes, year started:..... year stopped: .....

How many of the following do you smoke per day? Cigarettes ..... Cigars ..... Pipe.....

Alcohol Consumption

How often do you consume alcohol?

Never ☐ Monthly or less ☐ Fortnightly or less ☐ Once a week ☐ 2-3 days p/week ☐ 4+ days p/week ☐

When drinking, the number of standard drinks consumed:

1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+ ☐

Womens Health

How long ago was your last pap smear? .....How long ago was your last mammogram?.....

How long ago was your last breast ultrasound? ..... Results? .....

Mens Health

Have you ever had a prostate check? Yes ☐ No ☐ If so, when? .....

Immunisations / Vaccinations

Please indicate approximate date vaccinated:

Tetanus: ..... Pneumonia: ..... Hep A/B: ..... Chicken Pox: .....

Shingles: ..... Influenza ..... Whooping Cough: .....

Mental Health

Have you ever received medical attention or counselling for psychological or emotional issues?:

Yes ☐ No ☐ Please provide details.....

Have you ever been prescribed medication for psychological or emotional issues?

Yes ☐ No ☐ Please provide details.....

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Past Medical History

Have you been diagnosed with any of the following? Yes ☐ No ☐ If yes, please circle diagnosis:

Asthma Cancer Diabetes Arthritis Chronic Heart Disease

Have you ever had surgery or been hospitalised? Yes ☐ No ☐

Surgical Procedures / Dates.....

.....

Other Clinicians: GP / Specialist

Name: ..... Speciality: .....

Contact Details: .....

Name: ..... Speciality: .....

Contact Details: .....

Additional details/information that may help with your medical treatment:

Height: ..... Weight: .....

.....

Would you like to register with My Health here at this practice and upload your summary? Yes ☐ No ☐

I certify that the information supplied is true and correct to the best of my knowledge.

Signature: ..... Date: ...../...../.....

Parent/Guardian Name: (if under 16 years) .....

Please note: Undisclosed information, or inaccuracies in the information provided could result in an adverse outcome in relation to your medical treatment.