Patient Registration & Consent

Langford 6 DAY MEDICAL CENTRE

Patient Details

Title: _____
Family Name: _____
Given Name: _____
Middle Name: _____
Preferred Name: _____
Date of Birth: _____

Gender at Birth: F: ☐ M: ☐ Prefer not to say: ☐

Gender Identity: F: ☐ M: ☐ Other (please specify)

_____ or Prefer not to say: ☐

What are your Pronouns: _____

Ethnicity – What is your predominant heritage?

Australian, non-indigenous ☐
Aboriginal but not Torres Strait Islander ☐
Torres Strait Islander but not Aboriginal ☐
Both Aboriginal and Torres Strait Islander ☐
Not provided ☐
Other: _____
Country of Birth: _____
Language spoken at home: _____
Interpreter required Yes ☐ No ☐

Street No & Name: _____
Suburb: _____ Postcode: _____
Home No: _____ ☐ Work No: _____ ☐
Mobile No: _____ ☐
Email: _____

SMS** is routinely used by our practice; you will need to notify staff if you **do not wish** to receive **SMS

SMS : Yes ☐ No ☐
Email: Yes ☐ No ☐
(Please indicate your preferred method of contact above)

Medicare No: _____ Ref: _____
Expiry Date: _____
Pension/HCC No: _____ Type: _____
Expiry Date; _____
DVA No: _____ Type: _____
Occupation: _____

Next of Kin:

First Name: _____ Last Name: _____
Address: _____
Contact No: _____
Relationship: _____

Emergency Contact:

First Name: _____ Last Name: _____
Address: _____
Contact No: _____
Relationship: _____

Legal Guardianship in place:

First Name: _____ Last Name: _____
Address: _____
Contact No: _____
Email: _____
Copy of legal guardianship provided? **Y** ☐ **N** ☐

Carer:

First Name: _____ Last Name: _____
Address: _____
Contact No: _____
Email: _____
Relationship: _____

Allergies? Yes ☐ No ☐

If yes, please list:

_____

_____

HEALTH & OTHER INFORMATION

Do you drink Alcohol Y ☐ or N ☐ **Ex-drinker?** Y ☐ or N ☐
If Y How many days per week? If Y, Occasional ☐ Moderate ☐ Heavy ☐
No of standards drinks per day?
Current smoking history – Non-smoker ☐
Ex-Smoker ☐ Year stopped? _____ Quantity? _____ Per Day
Smoker ☐ Year started? _____ Quantity? _____ Per Day
Any significant family history? Y ☐ or N ☐ comments: _____
Mother: ☐ Diabetes? ☐ Hypertension? ☐ Heart disease? ☐ Stroke? ☐ Colon cancer? ☐ Depression? ☐ Breast Ca
Father: ☐ Diabetes? ☐ Hypertension? ☐ Heart disease? ☐ Stroke? ☐ Colon cancer? ☐ Depression? ☐ Cancer?
Mother alive? Y ☐ or N ☐ Age at death? Cause of death? _____
Father alive? Y ☐ or N ☐ Age at death? Cause of death? _____

Data entered by:

PTO

Privacy Statement & Consent

I understand that Langford Medical complies with the Privacy Act (1988) and the 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. Langford Medical makes every effort to manage personal information in accordance with the Australian Privacy Principles (APPs) contained within the Privacy Act 1988 (Cth) and to keep my records accurate, complete and up to date. I understand that I may withdraw my consent for Langford Medical to use and disclose my personal information (except where legal obligations are met)

Collection, Use & Disclosure

We recognize that the information we collect is often of a highly sensitive nature and as an organization we have adopted the highest privacy compliance standards relevant to ensure personal information is protected.

Langford Medical provides administrative and management services to the independent medical practitioners who consult from the practice. For administrative and billing purposes, and to enable the patient to be attended by other practitioners in our practice, patient information is shared between the practitioners who attend a patient. We (on behalf of) and the practitioners may collect personal information (including health information) regarding patients for the purpose of providing medical services and treatments to patients. Personal information collected will generally include, the patients name, address, telephone number, and Medicare number, health care fund, current drugs or treatments used by the patient, previous and current medical history, including where clinically relevant a family medical history, and the name of any health service provider or medical specialist to whom the patient is referred, copies of any letters of referrals and copies of any reports back.

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

- Langford Medical 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
- I acknowledge that any additional visits to external service providers such as pathology, specialists, imaging etc may incur an additional fee that is independent to the fees associated Langford Medical.
- I understand that my medical record may be reviewed by an authorised accreditation surveyor for the purposes of practice accreditation, quality assurance and compliance activities, subject to appropriate confidentiality obligations, .
- De-identified information may be collected, used and disclosed for quality improvement activities, research, accreditation requirements, public health planning and Primary Health Network (PHN) activities where permitted by law. The release of relevant personal information to my employer/prospective employer, their authorised representative, and their insurer in the case of a work-related consultation of service.
- I consent to receiving appointment reminders, recalls, preventative health reminders and other healthcare-related communications by SMS, email, telephone or mail.
- Langford Medical will collect information necessary for your treatment. This may include Full Medical and Psychological History.
- Where there is a serious and imminent threat to an individual's life, health, or safety, or a serious threat to a public health or public safety or as required under compulsion or law
- I consent my treating GP to bill Medicare for appropriate MBS item number in relation to my consultation/s and or treatment/care
- I consent for my treating GP to access MyHealthRecord and upload documents.
- I consent for a third party to be present at consultations when I need help understanding my health information
- I consent to relevant personal and health information being transmitted electronically to specialists, hospitals, allied health providers and other healthcare providers involved in my care through secure messaging systems including HealthLink, Medical Objects, My Health Record, secure email or other approved electronic communication platforms.
- I understand that electronic communications, including email and SMS, may not always be secure. While Langford Medical takes reasonable steps to protect my information, I acknowledge the inherent risks associated with electronic communication.

We may access information:

- provided directly by the patient
- provided on a patient's behalf with the patient's consent
- from a health service provider who refers the patient to medical practitioners,
- from health service providers to whom patients are referred to.

Other than as described in this Privacy Statement, Privacy Policy, or as permitted or required under the Privacy Act 1988 (Cth), Langford Medical uses reasonable endeavours to ensure that identifying health information is not disclosed to any person without appropriate authority.

Signed: _____ **Dated:** _____

Witness to signature:_____ **Dated:** _____