**Patient Information Record**

This registration form is used for several purposes. It comprises information necessary:

* to register you as a patient
* to form the basis of your medical record for The Surgery at Jerra health care providers
* to allow us to contact you if needed

***Information provided on this form is treated as strictly confidential and will not be provided to any person or entity without your permission. Similarly, it will only be used by us for the purposes listed above. Please review our practice brochure and privacy signage for more detailed information in regards to our privacy obligations.***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Ms Miss Mrs Mr Master Dr Other \_\_\_\_\_\_\_\_\_\_\_\_ | | | Medicare No |  | Ref |  |
| Surname |  | | | Medicare Expiry |  | | |
| First Name |  | | | Pension / HCC No |  | Expiry |  |
| Middle Name |  | | | Card Type |  | | |
| Preferred Name |  | | | DVA No and colour | Gold White | | |
| Date of Birth |  | | | Usual Dr (circle) | Dr Yates Dr Harvey-Smith Dr Cole Dr Dey Dr Ward Dr Pranavan Dr He Dr Gosling Dr Sung | | |
| Country of Birth |  | | | Ethnicity |  | | |
| Gender | Male Female Other | | | Current Occupation |  | | |
| Do you wish to be recognised as: Aboriginal Torres Strait Islander Both Neither (please circle) | | | | | | | |
| Address |  | | | Health Fund |  | | |
| Suburb |  | Postcode |  | Fund No |  | | |
| Home Phone |  |  |  | Next of Kin Name |  |  |  |
| Work Phone |  | | | Relationship to you |  | | |
| Mobile/SMS |  | | | Address |  | | |
| Email |  | | | Phone contacts |  | | |
| **By supplying your phone numbers and/or email address, you CONSENT to receive calls, verbal messages, SMS or SMN messages to your mobile phone (NOT advertising), and periodic newsletters to your email address.**  Opt out: □ SMS/SMN (NO appointment or health reminder will be sent!) □ Newsletter | | | | Emergency Contact Name and Number (if different to NOK) |  | | |
| Office use only | Form accepted by \_\_\_\_\_ Data entry by \_\_\_\_ | | |
| **Authorised Person**: I authorise the following person to act on my behalf in regards to access to my records, results and other information that may be held by TSAJ. I understand I can revoke this authority at any time by contacting The Surgery at Jerra in writing.  □ Use Next of Kin □ Other:  Authorised Person : Relationship to you:  Contact Details: Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile: Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **How did you hear about us?**  □ Word of mouth □ Radio □ TSAJ website □ Google search □ TSAJ Facebook page □ Professional referral □ Other social media | | | | | | | |
| **I have read the Privacy Policy and agree for correspondence to be sent to other clinicians involved in my care. I agree to be contacted as per my CONSENT. I also undertake to pay all fees owed to The Surgery at Jerra at the time of consultation.**  **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |

**As per Medicare and legal guidelines regarding patient privacy, authority for a parent/guardian/other of patients aged 16 and above will need renewal by the patient.**

**A Cancellation Fee may apply for patients who fail to attend for their appointment without giving suitable prior notice.**

The Surgery at Jerra aims to facilitate the provision of a range of what is commonly called primary care services. These include the areas of general practice, podiatry, asthma and diabetes education, mental health, physiotherapy, child, teen and aged health, dietetics (healthy eating), to name a few.

This relies on a proactive partnership approach to your health care; a partnership between yourself, the doctors, nurses and other health providers or educators that make up your health care team. While your health care team is led by your usual GP, you may not always need to see them. On occasions they will ask you to see another of the team care members who may have specific skills or knowledge that is best for the treatment of the condition. Your usual GP may even ask you to see another doctor in the practice who may provide further knowledge in your treatment or a second opinion.

The Surgery at Jerra is focused on providing the best care to you, from the most appropriate clinician.

To provide this level of integrated quality care, it is essential that your health care team know as much as possible about your existing (and past) health and lifestyle. As such all clinicians involved with your care will have access to your record.

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***PLEASE NOTE: NOT ALL QUESTIONS ARE APPLICABLE FOR EVERY PATIENT***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have any personal or  family history of: | **Nominate family member:** **(maternal/paternal grandparent, mother, brother, etc)** |  | | | **Nominate family member:** **(maternal/paternal grandparent, mother, brother, etc)** |
| Diabetes |  | Colon Cancer | | |  |
| Hypertension |  | Depression | | |  |
| Heart Disease |  | Breast Cancer | | |  |
| Stroke |  |  | | |  |
| Is your mother alive? | Yes No Age at death | Cause of death | | | |
| Is your father alive? | Yes No Age at death | Cause of death | | | |
| What is your Marital Status? |  | What is your sexuality? | | |  |
| Are you an Elite Athlete? | Yes No Sport? | Do you have a carer? | | | Yes No |
| What social / exercise activities do you engage in and how often? |  | | | | |
| What previous occupations have you had? |  | | | | |
| Do you currently drink alcohol? Yes No | About how many days of the week do you drink?  1 2 3 4 5 6 7 | | | How many each day?  1 2 3 4 5 6 or more | |
| Prior to current alcohol consumption | Nil Light Moderate Heavy | Year started | | | Year stopped |
| Do you currently smoke? | Yes No About how many cigarettes per day? | | | |  |
| Prior to current smoking activity | Nil Light Moderate Heavy | Year started | | | Year stopped |
| What prescription drugs do you take?  Please list the drug and dosage |  | | **ALLERGIES:** | | |
| What over the counter drugs do you take?  Please list the drug and dosage |  | | | | |

**I acknowledge that the information provided on this registration and information form is correct to the best of my knowledge.**

Your Signature: Date: