EMERALD MEDICAL CENTRE
LANE COVE

NEW PATIENT REGISTRATION FORM

Welcome To Emerald Medical Centre Lane Cove, Registered General Practice.

To assist us in ensuring your information is correct, please complete the following details. Once completed, please hand to a receptionist along with your Medicare Card and your Pensioner Card/ Health Care Card if you have been issued with one.

Please make sure the name written is exactly as shown on your Medicare card.

SECTION A : Personal details

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Mast. ☐ Dr. ☐ Other_____		
Surname: **Given Name:** **Preferred Name:**		
Date of Birth: / /	**Gender:** ☐ Male ☐ Female ☐ Other _____	
Ethnicity/ Culture Background: ☐ Australian, non-indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander. ☐ Other, please specify _____		**Do you require an interpreter?** ☐ No ☐Yes, Language: _____
Address: **Suburb:** **Postcode:**		
Mobile: ☐E-script	**Home phone:**	**Work Phone:**
Email:		**Occupation:**
Medicare Number: **Ref no:**		**Expiry Date:**
Pensioner Card No. :		**Expiry Date:**
Health Care Card No.:		**Expiry Date:**
Seniors Health Card No.:		**Expiry Date:**
DVA Number : ☐ Gold ☐ White ☐ Orange		**Expiry Date:**
Next to Kin: **Full name:** **Relationship:**		**Phone:**
Emergency Contact: ☐ Same as Next to Kin **Full name:** **Relationship:**		**Phone:**

PLEASE TURN OVER THE PAGE.

SECTION B : Medical History

Height (cm): **Weight(kg) :** **Waist(cm):**
Do you Exercise? ☐ No ☐Yes **What's the level: ☐ Inactive ☐ Moderate ☐ Active** **What activities?** **☐ Gentle walking ☐ Brisk walking ☐ Swimming ☐ Gardening ☐ Dancing ☐ Exercise class ☐ Jogging** **☐ other, please specify _____ • Frequency: _____minutes/day; _____times/ week.**
Do you have any ALLERGIES ? ☐ Nil known ☐Yes, please specify
Are you taking any medications currently? ☐ No ☐Yes, please specify
Past Medical History: ☐ No ☐Yes, please specify below **☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Other _____**
Family Medical History: ☐ No ☐Yes, please specify below **☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Other _____**
Do you Smoke? **☐ Non Smoker ☐ Ex Smoker _____cigarette/day; Year started:_____; Year stopped:_____.** **☐ Occasional ☐ Smoker _____cigarette/day; Year started:_____.**
Do you Drink Alcohol? **☐ Non Drinker ☐ Ex Drinker _____drinks/week; Year started:_____; Year stopped:_____.** **☐ Occasional ☐ Drinker _____drinks/day; _____ days/week; Year started:_____.**

SECTION C : Consent

OUR PRIVACY AND MEDICAL INFORMATION

Complying with The Privacy Act, your consent is required for information collected. This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management, in which your consultation may include the presence of a medical student or GP registrar. All information is de-identified. If you wish to opt out of any research undertaken by the clinic -- please inform your doctor. We always wish to assure you that your health information is treated with utmost confidentiality. In accordance with medical legislations, doctors and staff in this practice will not discuss test results over the phone and results are only authorized to release by our Doctors.

OUR COMMUNICATION

By signing this form, you acknowledge that appointment reminders, follow-up reminders and report recalls will be communicated via SMS. This is a courtesy service that we offer, it may not be sent on all occasions and you have the responsibility for making, attending, or cancelling appointments for your recall results. You reserve the right to opt out the SMS service at any time, however, you may not be contacted for recalling the results if your phone number provided is not contactable. You are acknowledged that the risk if you request the results to be send by the email you provided.

YOUR RESPONSIBILITIES

Patients are required to return for a consultation to obtain test results, preferably with the doctor who ordered your tests. If any results are abnormal and/or require urgent attention, we will contact you. Please make sure reception has your current phone number and address details when booking or settling your account. It is crucial that you understand that this is your responsibility to ensure you contact and return for your results.

- ✔ By signing this form, you are agreed that that any outstanding fees are payable at time of the consultation
- ✔ Investigations/specialists fees: all fees outside our practice is not within our scope, please double check fees prior investigations/ specialist appointments.
- ✔ By completing the field above, I understand and agree to all the conditions for the service provided by Emerald Medical Center Lane Cove.

SIGNATURE OF PATIENT/GUARDIAN:_____ DATE: / /