



PO Box 315
23 Nairne Road
WOODSIDE SA 5244
Ph: 8389 7232 Fax: 8389 9032
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Email: woodside@onehealthcare.org.au

PATIENT REGISTRATION FORM

Form filled in by Mr / Ms / Mrs Relationship to child

Title: Master /Miss/Other Given Name:

Family Name: Preferred Name:

Date of Birth:/...../..... Gender: Male/Female/Others (please specify)

Medicare No..... Ref No..... Expiry Date:/...../.....

Concessions: Card type: Card No: Expiry Date:/...../.....

Street Address:

..... Suburb: Postcode:

Postal Address: (if different):

Country of Birth: If not born in Australia, year of arrival in Australia:

Ethnicity: Is the child identified as an Aboriginal and/or Torres Strait Islander?

Next of Kin: Phone: Relationship:

Emergency Contact: Phone: Relationship:

For communication, parent/guardian's:

Home Phone: Work Phone: Mobile phone:

E-mail Address: Occupation:

HEALTH HISTORY

Does your child have any allergies? Medication/Dressing/Food? Please elaborate

Does your child have history of the following? If yes, please elaborate.

Pre-term birth / Asthma / Diabetes / Any other chronic illness

CURRENT MEDICATIONS, including vitamins, minerals etc.

.....

FAMILY HISTORY

Father: Diabetes/Hypertension/Heart disease/Stroke/Colon Cancer/Depression/Others

Mother: Diabetes/Hypertension/Heart disease/Stroke/Colon Cancer/Depression/Others

IMMUNISATION STATUS

- Childhood immunisation: Up to date / On catch up program / Unimmunised
Any other vaccinations done:

REMINDER SYSTEMS

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks etc. These would be mailed/texted to you on behalf of your child. Please indicate if you do not wish to have relevant health reminders sent to you.

How did you hear about our Surgery?



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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 and treat and be proactive in your health care needs. We aim to protect the privacy and ensure secure storage 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

- Administrative purposes in running our medical practice
Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
Disclosure to other doctors in the practice, locums and Allied Health Professionals (physiotherapist, podiatrist, clinical psychologist) attached to the practice for the purpose of patient care and teaching, and specialists outside of this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
For research and quality assurance activities to improve individual and community health 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 legislation 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 or 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 obligated to provide any information requested of me, but failure to do so may compromise the quality of the health care and treatment given to me.
I am aware of my rights to access the information collected about me, expect in 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 understand that depending on the age of my child (16 and over) and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.
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.

If you are unsure about any of the above and would like to discuss this further with someone from the practice, please do so before you sign.

Patient's name: Signature: Date: / /

Signed as Guardian for child: Name (printed):

FOR OFFICE USE

FORM PROCESSED BY: SIGN: DATE: