OCEAN WAVE MEDICAL PATIENT INFORMATION

This information is private and confidential
(please return this page to reception on completion)
DOC: CEN005 updated August 2019

SURNAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

Date of Birth:_____ Country of Birth: _____ Ethnicity:_____

SEX: Male/Female/Other: _____

MARITAL STATUS: Single/Married/ Widowed/Divorced/Separated/ Defacto/ Same sex

Do you identify as Aboriginal and/or Torres Strait Islander (Please circle) NCACCH number_____(if applicable)

Is English you first language? Yes / No Primary Language_____ Do you require and interpreter? Yes / No

Residential Address: _____

Postal Address (if different to home): _____

Email address: _____

Phone: _____ Mobile: _____ Work: _____

MEDICARE NUMBER:_____ REF NO:_____EXPIRY:_____

PRIVATE HEALTH FUND NAME: _____ NUMBER:_____ EXPIRY:_____

PENSION or HEALTH CARD (Please circle) NUMBER: _____ EXPIRY:_____

VET AFFAIRS CARD NUMBER (DVA):_____ EXPIRY:_____

(Please circle) Gold White Lilac Orange

RELIGION: (if applicable)_____ OCCUPATION:_____

Next of Kin: _____ Relationship: _____

Phone: _____ Mobile:_____ Work:_____

Emergency Contact Name: _____Relationship: _____

Phone: _____ Mobile:_____ Work:_____

It is recommended that your Emergency Contact should be separate person to your Next of Kin

How did you find out about our surgery? *(Please Circle)*

Word of mouth Drive/walk past Facebook Website Holiday/Accom

Yellow Pages Newspaper Pharmacy Relative Internet Search

If you wish to Transfer your Medical Records to us, please complete form at Reception

OCEAN WAVE MEDICAL – NEW PATIENT REGISTRATION

Page 2 – CLINICAL INFORMATION

PATIENT NAME: _____ DOB: _____

MEDICAL INFORMATION: (please circle or fill in your response)

Do you have any known allergies?	**No Yes** **If yes, please list:**
Please list any medications that you are currently taking (including vitamins and herbal medicines): Name of medication: _____ Strength: _____ Daily Dose: _____ Name of medication: _____ Strength: _____ Daily Dose: _____ Name of medication: _____ Strength: _____ Daily Dose: _____ Name of medication: _____ Strength: _____ Daily Dose: _____ Name of medication: _____ Strength: _____ Daily Dose: _____	
Smoking ☐ Non-smoker ☐ Smoker**:** How many a day ___ ☐ Ex-smoker – year stopped_____ **Alcohol** ☐ Non-drinker ☐ Drinker- how many days/week____ How many std drink/day _____	
PATIENT HISTORY (Please circle the most appropriate answer and fill out all other areas) Diabetes Asthma High Blood Pressure Heart Problems Depression Stroke Kidney Disease Breast Cancer Epilepsy Colon Cancer Other Cancers:	
Do you know your blood type?	**No Yes If yes Type:**
Female Patients – Year of last Pap smear/cervical screen	
Do you have an advanced health directive	**No Yes**
Do you have an Enduring Power of Attorney	**No Yes:**
Are you registered with My Aged Care?	**No Yes**
FAMILY HISTORY	Unknown (adopted) No significant history (Please circle)
Mother – still alive Mother history of (Please circle)	Yes or No If no age of Death: Diabetes Kidney Disease Asthma Epilepsy High Blood Pressure Breast Cancer Stroke Colon Cancer Depression Other Cancers:
Father – still alive Father history of (Please circle)	Yes or No If no age of Death: Diabetes Kidney Disease Asthma Epilepsy High Blood Pressure Breast Cancer Stroke Colon Cancer Depression Other Cancers:
Other immediate family members significant illnesses:	Please List:
Children	Please provide a copy of child's immunisation list

Nurses to complete:

Blood pressure _____ Temperature_____ Pulse_____ Height_____

Weight _____ O2 Sat's_____ Head Circumference_____

OCEAN WAVE MEDICAL NEW PATIENT CONSENT AND COLLECTION OF PERSONAL INFORMATION

We need this information on our Patient Registration form to provide the best quality care. This form complies with the RACGP Standards for general practices (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please discuss with your GP. Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical record and allow us to contact you promptly about tests and results.

CONSENT

Our Practice uses a reminder system to help you maintain your health. The practice sends reminders and recalls via sms, telephone, email or mail for procedures such as vaccines, pap tests and other health reviews, or recall for results.

I consent to being contacted with reminders to help me maintain my health: Yes No

Our practice also sends information to the Australian Immunisation Register (AIR) and the Pap Smear Register. These registers also send reminders, which can be helpful if you move.

I consent to being contacted with reminders to help me maintain my health: Yes No

PERSONAL INFORMATION

Our practice will collect your personal information:

1. When you make your first appointment, our practice staff will collect your personal and demographic information via your registration.
2. During the course of providing medical services, we may collect further personal information.
3. We may also collect your personal information when you visit our website, send us an email or SMS, telephone us, make an online appointment or communicate with us using social media.
4. In some circumstances, personal information may also be collected from other sources. Often this is because it is not practical or reasonable to collect it from you directly. This may include information from: your guardian or responsible person. Other involved healthcare providers, such as specialists, allied health professionals, hospitals, community health services and pathology and diagnostic services and your health fund, Medicare, or the department of Veteran's Affairs (as necessary).
   DOC CEN 161 – KEEPING YOUR PERSONAL INFORMATION PRIVATE IN OUR PRACTICE is available for you at reception.

By becoming a patient of Ocean Wave Medical and signing this form I agree and Consent to:
The collection of my personal information. Receiving recalls and reminders for preventable health plus appointment reminders via SMS and/or post.

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE:_____

PRACTICE USE ONLY:

Witnessed by: (Staff Name)_____