OCEAN WAVE MEDICAL
Excellence in Family Medicine

OCEAN WAVE MEDICAL PATIENT INFORMATION

This information is private and confidential
(please return this page to reception on completion)
DOC: CEN005 updated June 2021

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: 75+ HA? Y / N - GPMP/TCA ? Y / N - Identified as ABTSI ? Y / N

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.

FAILURE TO ATTEND YOUR APPOINTMENT

A $20 FEE WILL BE CHARGED IF YOU FAIL TO ATTEND YOUR APPOINTMENT. OUR DOCTORS ARE BOOKED OUT WELL IN ADVANCE AND PATIENTS ARE WAITING FOR APPOINTMENTS. IF YOU CANNOT ATTEND YOUR APPOINTMENT, PLEASE GIVE AT LEAST 2 HOURS NOTICE TO OUR RECEPTIONISTS SO WE CAN OFFER TO ANOTHER PATIENT.
ANYONE NOT ATTENDING THEIR APPOINTMENT OR GIVING LESS THAN 2 HOURS NOTICE WILL BE BILLED $20.
THIS INVOICE WILL NEED TO BE PAID BEFORE ANOTHER APPOINTMENT CAN BE BOOKED.
THANK YOU FOR YOUR UNDERSTANDING.

SIGNATURE OF PATIENT OR GUARDIAN: ____________________ DATE:________________

Witnessed by: (Staff Name)____