BIBRA LAKE MEDICAL CENTRE

New Patient Registration Form

We require this information to provide the best quality care. This form complies with the RACGP Standards for General Practices. This means your personal health information is kept private and secure as required by Federal & State Privacy Laws.

Section A: PERSONAL DETAILS

Surname:	**First Name**:	**Preferred Name**:
Title: ☐Mr ☐Ms ☐Mrs ☐Miss ☐Master ☐Dr Other_______	Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced	Date of Birth: / /
Occupation: ________________________ Gender: ☐Male ☐Female ☐Other Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Expiry: ☐☐☐ Ref No: ☐ (Next to name)	Veterans Affairs Number: ☐☐☐☐☐☐☐☐☐☐ WHITE: ☐ ORANGE: ☐ GOLD: ☐ Pension card number: ☐☐☐ - ☐☐☐ - ☐☐☐☐ Expiry: ☐☐☐ Health Care Card number: ☐☐☐ - ☐☐☐ - ☐☐☐☐ Expiry: ☐☐☐	Family Ethnicity: (Aboriginal/TSI; Other) ______________________________ Country of birth: ________________ *Knowing your cultural background can assist us to provide healthcare that meets your individual needs. Mobile Number: ☐☐☐☐☐☐☐☐☐☐ Consent to SMS for reminders & recalls: ☐Yes ☐ No
Home Address: ____ ______________________________ Postcode: ________		Work Phone: ___________________ Home phone: ___________________ Email: _____________________ @ ______________________________
Next of Kin:	Relationship to you:	Phone Number:
Emergency Contact:	Relationship to you:	Mobile:

Do you require a translator? ☐Yes ☐No Language:

How did you find out about our surgery?

Word of Mouth Drive/walk past Leaflets/Flyers Health Engine HotDoc Other – Specify:

At BLMC we strive to provide high quality care, appropriate to meet our client's health care requirements. Your feedback is important to us. Please feel free to fill in a Feedback/Suggestions form at reception or alternatively, please utilise the Happy or Not Terminal on your way out.

PLEASE TURN OVER

IMPORTANT INFORMATION FOR NEW PATIENTS

Cnr Annois Road and Parkway Roads, Bibra Lake WA 6163
Telephone: (08) 9417 2600 Facsimile: (08) 9417 7664
www.bibralakemedical.com.au

PLEASE NOTE THAT THIS IS A PRIVATE BILLING PRACTICE. Our billing policy is at the discretion of each doctor. Children 16 and under, Health Care, Pension & DVA card holders will be Bulk Billed.

We welcome new patients to our family friendly practice. Please find below a list of our Practice Policies:

- **Fees and Billing arrangements**: We are a private billing practice and fees are payable at the time of consultation. We accept cash, EFTPOS, MasterCard and Visa.
- GPs at our practice bulk bill children **16 and under** and **Veterans Affairs** patients. GPs also bulk bill **Pensioners** and current **Health Care** card holders.
- **Results and Recalls**: Generally, if you need a follow up appointment for results you will receive an SMS, a phone call or a recall letter if it is a non-urgent result. Our nurses will contact you if it is an urgent recall.
- **Prescriptions**: All prescriptions require a medical appointment with your GP. If this is not possible, at the discretion of the doctor, a script may be written without an appointment. A fee of $15.00 will be charged.
- **Referrals**: Please note that it is illegal for doctors to backdate a referral. You need to ensure your referral is up to date before you see your specialist or you will not be eligible for a rebate from Medicare.
- **Cancellation Policy**: We understand that sometimes extenuating circumstances prevent patients from attending appointments. Where possible please give us at least 2 hours' notice if you need to cancel your appointment. A no-show fee of $50 may apply for non-attendance, this is at the discretion of the doctor.
- **My Health Record** is the Australian digital health record system. Having a My Health Record means your important health information like allergies, medical conditions, immunisations, medication details, tests or reports can be accessed anywhere you are able to go online.
- **Complaints**: If you have a complaint please let us know, we want to help. Alternatively, you can contact Health, Disability and Mental Health service complaints and enquiries on (08) 6551 7600 or 1800 813 583.

PRIVACY STATEMENT

Your Personal Health Information and your Medical Records may be collected, used and disclosed, including but not limited to, the following reasons:

- For communicating relevant information with other treating doctors, specialists or allied health professionals
- For follow up reminder/recall notices
- For disease notification as required by law (e.g. infectious diseases)
- For use by all doctors in this group practice, when consulting with you
- For research purposes (de-identified, meaning you are not able to be identified from the information given)
- For obtaining previous pathology and radiology results.

If you have any concerns or wish to restrict access to your personal health information, please discuss this with your doctor. For further information, please ask one of our friendly reception staff.

Once you have read the above information, please sign below to indicate you have read and understood our policies.

Print: ________________________________ Sign: ____________________________ Date: __________

Welcome to Bibra Lake Medical Centre – we look forward to assisting you on your journey toward optimal health.

PLEASE COMPLETE PAGES 3 & 4

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PLEASE TAKE PAGES 3 & 4 TO THE DOCTOR

Mr / Mrs / Ms / Miss / Dr / Mstr **Surname:** ______________________ **First Name:** ______________________

DOB: / /

Section B: ALLERGIES & MEDICATIONS

Do you have any allergies? ☐ **Yes** ☐ **No**

If yes, List Allergies and intolerances to medication	**Describe your reaction/severity**

List regular medications and doses

Are you sensitive to any drugs or dressings? ☐Yes ☐No

IMMUNISATIONS

Immunisations Have you had these Immunisations?	**Immunisation**	**Yes**	**Year**	**No**	**Uncertain**
	Tetanus booster				
	Hepatitis B				
	Hepatitis A				
	Influenza				
	Shingles				
	Whooping cough				
	Pneumococcal /pneumonia				

If completing this form for a child, is their immunisation up to date? ☐Yes ☐No ☐ Unsure

Section C: YOUR HEALTH HISTORY

Are you currently being treated by a health professional for any illness or injury? ☐Yes ☐No

Do you have any current or previous medical conditions?	**YES**	**NO**	**DATE**
1. High blood pressure			
2. Heart disease			
3. Asthma			
4. Seizures, fits, convulsions, epilepsy			
5. Stroke			
6. Diabetes			
7. Cancer – please state:			
8. Mental health condition			
9. Blood clots or bleeding disorder			
10. Other – please state:			

PLEASE TURN OVER & COMPLETE PAGE 4

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Have you ever had an operation?	Date of procedure

Do you know your blood group?	☐Yes – what group?	☐No
Height: cm Weight: kg	Waist circumference: cm	

Have you ever had a colonoscopy?	☐Yes	☐No

FEMALES

Have you had a Cervical Screen Test? (formerly Pap Smear)	☐Yes ☐No Date: Hysterectomy ☐
	Result:
Have you ever had a mammogram?	☐Yes ☐No Date:

Section D: SOCIAL HISTORY

Are you a smoker?	☐Yes	☐No	☐ Ex-Smoker _______ years ago	
	If yes, how many per day?			
Past Smoking History:	☐ Nil	☐ Light	☐ Moderate	☐ Heavy
Do you drink alcohol?	☐Yes	☐No		
	How many days per week?		How many std drinks per day?	
Past Alcohol History:	☐ Nil	☐ Occasional	☐ Moderate	☐ Heavy

Section E: FAMILY HISTORY

Family History:	☐ Unknown (eg. adopted)			
Mother: Still Alive?	☐ Yes	☐ No	If No, Age at Death:	Cause of Death:
Father: Still Alive?	☐ Yes	☐ No	If No, Age at Death:	Cause of Death:

In there a history of any of the following medical conditions in your family?	YES	NO
1. High blood pressure		
2. Heart disease		
3. Asthma		
4. Seizures, fits, convulsions, epilepsy		
5. Stroke		
6. Diabetes		
7. Cancer – please state:		
8. Mental health condition		
9. Blood clots or bleeding disorder		

Thank you. We warmly welcome you to our practice.