St. Andrews Health

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https://standrewshealth.com.au/

NEW PATIENT REGISTRATION FORM

We are committed to providing our patients with the best care. To do this, it is essential that your health records contain complete and accurate information.
Please assist us by completing your new patient record form:

Title:	Mr. ☐	Mrs. ☐	Miss ☐	Ms. ☐	Mstr ☐	Dr ☐	☐ other			
Surname:										
First Name:										
Date of Birth:										
Marital Status:	Single ☐	Married ☐	De facto ☐	Separated ☐	Divorced ☐	Widowed ☐				
Street Address:										
Suburb:								Post Code:		
Home Phone:										
Mobile:										
Email:										
Occupation:										
Medicare Number										Expiry Date:
Health care Card Number:										Expiry Date:
Pension Number:										Expiry Date:
DVA Number						Card Type:				Expiry Date:

CULTURAL IDENTITY
Knowing your cultural background can help us provide healthcare that meets your individual needs

TO ASSIST WITH HEALTH INITIATIVES - DO YOU IDENTIFY YOURSELF AS:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Country of Birth:_____ Ethnicity: _____

EMERGENCY CONTACT DETAILS

Name:_____ Relationship to you: _____

Home Phone:_____ Mobile Phone: _____

EMERGENCY CONTACT *(if different to above) :*

Mobile Phone:_____ Home Landline Phone:

HEALTH PROMOTING AND PREVENTATIVE CARE:

Preferred method of contact

☐ SMS ☐ Mobile phone ☐ Home phone ☐ Letter ☐ Email (note email is not encrypted and may breach privacy).

Do you consent to the following? Consent will be presumed if you fail to respond to each of the below: Information to be sent to Government Registers e.g., Cervical screening (pap) and immunisation	Yes: ☐	No: ☐
SMS appointment reminders and test results	Yes: ☐	No: ☐
Uploading clinical documents to My Health Record?	Yes: ☐	No: ☐
If you would like a health summary or event summary uploaded to your My Health Record, ask GP during consult		
Sharing of NON-IDENTIFIABLE data with our local Primary health Network	Yes: ☐	No: ☐
Health promotion and preventative care reminders by post, email, telephone, or SMS?	Yes: ☐	No: ☐

How did you hear about us?

☐ Google ☐ social media ☐ HOTDOC ☐ Health Engine ☐ Walking past clinic ☐ Other (please state)

MEDICATIONS AND SOCIAL HISTORY

Please include ALL tablets, inhalers, patches, gels or injections – as well as any other ''natural'' remedies or supplements

CURRENT MEDICATION:

ARE YOU VACCINATED AGAINST COVID-19 VIRUS?	☐ YES	☐ NO
DO YOU HAVE ANY ALLERGIES?	☐ YES (*please list below*)	☐ NO

PREVENTATIVE HEALTH: Please tick the boxes where appropriate

Height:	Weight:
Smoking ☐ No ☐ Ceased - date ☐ Yes - how many_____day /_____week	Alcohol ☐ *No* ☐ *Yes - how many_____day /___week /_month*
Bowel Screening Date:	Skin Check Date:

FEMALES		MALES	
Pap smear Date:	Mammogram Date:	Prostate check Date:	Health check Date:

St. Andrews Health is a BULK BILLIING PRACTICE.

BULK-BILLING IS ROUTINE: you will receive an account for your visit which must be paid on the day of consultation.
Extra Payments can be made by eftpos or credit card.

Certain medical examinations – such as medicals, legal reports & commercial driver's licenses are not claimable from Medicare.
If you require any further information regarding cost of these please ask reception staff.
Full Payment is required on day for Workcover claims that do not currently have a claim number. You are then able to follow this up with your claim agent.

Freedom of information:
All patient files that include personal information, test results etc. are the property of this practice. However, should you choose to visit another Doctor at any time, copies of the appropriate files can be forwarded on receipt of your written request.
Under no circumstance will this practice divulge personal information without your prior written consent.

St. Andrews Health has a zero tolerance towards violence and aggression towards team members.

Cancellation/No show Policy*:*
We understand that unplanned issues can arise, and you may need to cancel an appointment. Should this occur, we respectfully ask that scheduled appointments are cancelled at least 24 hours in advance. A cancellation fee of $50.00 may apply if inadequate notice is given.

Please return the completed form to reception.
Thank you

I have read & understand all the information provided above regarding fees, privacy & freedom of information.
I also am aware that at the conclusion of all consultations there will be a request for full payment of the account.

PATIENT NAME: **(Patient unable to sign OR Underage complete below)** GURDIAN NAME:	SIGNATURE: SIGNATURE:	DATE: DATE: