PATIENT REGISTRATION FORM

Mount Respiratory
Perth Sleep Clinic
Dr Michael Prichard MB BS FRACP: Director

Title: Miss☐ Ms☐ Mrs☐ Mr☐ Dr☐ Prof☐ Rev☐

Surname:

First Names:

Preferred Name:

Street Address:

Town/Suburb:

Post Code:

Home Phone

Work Phone:

Mobile:

Facsimile:

Perth Contact:

Contact Name:

Email:

Postal Address:

Complete if different from main address

Town/Suburb:

Post Code:

Next of Kin:

Contact No:

Date of Birth: ___ / ___ / _____

Place of Birth: Migrated: _____

Occupation:

Habitation: Lives: ☐with parents ☐alone ☐with partner

Partner: Duration of relationship: _____

Medicare No: __ __ __ __ __ __ __ __ __ __ __ __

Ref No/Expiry: Ref: ___ Exp: ___ / ___

Pension/DVA: ☐Yes ☐No DVA Card Colour: _____
(Please circle)
Card No:

Private Insurance: ☐ Yes ☐ No

Fund Name:

Cover: ☐ Hospital ☐ Ancillary ☐ Both

Card No:

Referring Dr:

Location:

Usual Family Dr:

Location:

Workers Compensation: ☐ Yes ☐ No

Workers Compensation No:

Insurance Company:

Motor Vehicle Insurance: ☐ Yes ☐ No

Insurance Co:

Medico-legal Review: ☐ Yes ☐ No

PRIVACY ACT 1988 - PATIENT CONSENT TO COLLECT & DISCLOSE INFORMATION

The Privacy Act 1988 requires medical practitioners to obtain consent from their patient to collect, use and disclose that patient's personal information.

Collection

This means we collect information that is necessary to properly advise and treat you. Such necessary information may include:

- full medical history
- family medical history
- ethnicity
- contact details
- Medicare / private health fund details
- genetic information
- billing / account details

The information will normally be collected directly from you. There may be occasions when we will need to obtain information from other sources, eg:

- other medical practitioners, such as former general practitioners and specialists
- other health care providers such as physiotherapists, psychologist, pharmacists, dentists or nurses
- hospitals and day surgery units

Both our practice staff and the medical practitioners may participate in the collection of this information. In emergency situations we may need to collect personal information from relatives or other sources where we are unable to obtain your prior express consent.

Use & Disclosure

With your consent, the practice staff will use and disclose your information for purposes such as:

- account keeping and billing purposes
- referral to another medical practitioner or health care provider
- sending of specimens such as blood samples for analysis
- referral to a hospital for treatment and / or advice
- advice on treatment options
- the management of our practice
- quality assurance, practice accreditation and complaint handling
- to meet our obligations of notification to our medical defence organizations or insurers
- to prevent or lessen a serious threat to an individual's life, health or safety
- where legally required to do so, such as producing records to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases
- to make available your health records to an on call consultant, for your medical treatment, when the need arises
- to supply results / reports / recommendations to your referring doctor pertaining to your medical management

Access

You are entitled to access your own health records at any time convenient to both yourself and the practice.

Access can be denied where:

- to provide access would create a serious threat to life or health
- there is a legal impediment to access
- the access would unreasonably impact on the privacy of another
- your request is frivolous
- the information relates to anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings
- in the interests of national security

We ask that, where possible, your request be in writing. We may impose a charge for photocopying or for staff time involved in processing your request. Where you dispute the accuracy of the information we have recorded, you are entitled to correct that information. It is our practice policy that we will take all steps to record all of your corrections and place them with your file, but will not erase the original document.

Consent

I provide my consent for Mount Respiratory & Perth Sleep Clinic to collect, use and disclose my personal information as outlined above.

I provide consent for results to be sent to my referring doctor by facsimile.

I provide consent for messages to be left with immediate family members/defacto partners (eg appointment confirmation).

I understand that I am entitled to access my own health records, except where access would be denied as outlined above.

I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Patient Name: _____ Patient Signature: _____

Witnessed: _____ Date: _____
(Mount Respiratory/Perth Sleep Clinic Representative)

CONFIDENTIAL MEDICAL HISTORY

Name: _____

Please state in your own words why you have been referred to this practice: _____

_____

Have you ever had any illness or operation, or been in hospital (at any stage in life)? ☐Yes ☐No

Please indicate what **operations** you have had, and when:

Year or Age	Operation	Reason for Operation	Hospital (If applicable):

Examples: tonsillectomy; appendicectomy; hernia repair; cholecystectomy (gall bladder); sinus or nose surgery; skin cancer; etc

Please indicate what **illnesses** you have had, and when:

Year or Age	Illness	Medication or Treatment	Hospital (If applicable):

Examples: asthma, hay fever, high blood pressure; diabetes; infections; arthritis; etc

Check list: have you had any of the following?

	Y	N		Y	N		Y	N
Asthma			Angina			Diabetes		
Bronchitis			Heart attack			Thyroid disease		
Pneumonia			Heart failure			Headache disorder		
Tuberculosis			High blood pressure			Migraine		
Pleurisy			Blood clot			Stroke		
Pneumothorax			Irregular or fast heart			Epilepsy (fits)		
Chest injury			Kidney stones			Paralysis		
Abnormal Chest X-ray			Nephritis			Depression		
Abnormal breathing tests			Urinary tract infection			Anxiety or panic disorder		
Hayfever			Peptic ulcer			Problem sleeping		
Eczema			Hiatus hernia			Arthritis		
Hives (welts)			Gastric acid reflux			Gout		
Insect bite			Hepatitis			Easy bleeding		
Medication allergy			Pancreatitis			Tropical disease		
Food reactions			Colitis (UC or Crohn's)			Anaemia		
Sinusitis			Irritable bowel syndrome			Cancer		
Hearing loss			Diverticular disease			Septicaemia		

Smoking history: Y N

Have you ever smoked as much as one cigarette per day for as long as one year?

How old were you when you started smoking? Age (yrs)

How old were you when you last smoked? Age (yrs)

How many cigarettes per day (or tobacco per week [pack size = 2oz or 50g]) do/did you smoke?

Cigs/day☐ g/wk☐

Alcohol consumption: Y N

Have you ever consumed alcohol on a regular basis?

Have you ever consumed alcohol to excess?

Have you ever had to seek medical or other help for alcohol abuse?

What type of alcohol do you usually consume? Beer☐ Wine☐ Spirits☐ Quantity/day:

Allergies: Y N

Are you allergic to any medication? (if Yes, please indicate the medications and type of reaction below)

Reaction:

Reaction:

Reaction:

Medications (please list all current medications):

Drug name	Dose	Times/day	Reason	Date started

Family history:

Relation	Name	Alive?	Medical Disorder, Illness or Cause of Death
Father			
Mother			

Examples: asthma, allergies, hay fever, tuberculosis, cancer, heart disease, blood diseases, genetic disorders etc