

Nelson Plaza Clinic Patient Registration Form

Information provided on this form is treated as strictly confidential and will not be provided to any person or entity without your permission. Our practice brochure and privacy policy is available at the clinic.

Please complete and return this form:

■ In person: 29 Stockton St, Nelson Bay ■ By fax: 02 4981 2755 ■ By mail: PO Box 755, Nelson Bay NSW 2315

Title	Ms Miss Mrs Mr Master Dr Prof Other	Medicare Card No.	
Surname		Medicare Line No.	Exp Date
First Name		Circle: Pensioner Concession / Health Care Card / Seniors Health Card	
Middle Name		Concession Card Number:	
Preferred Name		Exp Date:	
Date of Birth		DVA Card No. and Colour	Gold White
Sex	Male Female	DVA Conditions	
Gender Identity	Please circle: Female / Male / Non-binary / Gender Diverse / Transgender / Different Identity	Ethnicity / Nationality	
Do you wish to be recognised as an: Aboriginal Torres Strait Islander Neither (please circle)			
Home Address		Postal Address (if different)	
Home Phone		Email	
Mobile		Religion (optional)	
Work Phone		Current Occupation	
Emergency Contact (who we can ring in case of an emergency):			
Name: _____ Relationship to you: _____			
Phone number: _____ Mobile number: _____			
Name of Usual Doctor: _____			
Privacy and Consent			
In some circumstances, we will need to contact you to confirm specific appointments and matters regarding your health. Contact maybe on your answering machine, message bank, SMS message or by email.			
Please indicate below the types of communication you consent to receiving by ticking the box.			
Appointments	<input type="checkbox"/> I consent to receiving a reminder via SMS of my upcoming appointment		
Clinical Communication	<input type="checkbox"/> I consent to communication being sent to me about investigation results and other clinical information		
Clinical Reminders	<input type="checkbox"/> I consent to reminders regarding clinical appointments such as, Care Plan Reviews or immunisations.		
Health Awareness	<input type="checkbox"/> I consent to receiving health awareness communication that may be relevant to me, or important information on services the practice provides		
Opt Out of De Identified Data Extraction: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signed: _____		(Self or Guardian)	Date: _____

Nelson Plaza Clinic Medical, Health & Lifestyle Information

Nelson Plaza Clinic aims to facilitate the provision of a range of what is commonly called primary care services. These include the areas of general practice, podiatry, asthma and diabetes education, mental health, physiotherapy, child, teen and aged health, dietetics (healthy eating), to name a few.

This relies on a proactive partnership approach to your health care, a partnership between yourself, the doctors, nurses and other health providers or educators that make up your health care team. While your health care team is led by your usual GP, you may not always need to see them. On occasions they will ask you to see another of the team care members who may have specific skills or knowledge that is best for the treatment of your condition. Your usual GP may even ask you to see another doctor in the practice that may provide further knowledge in your treatment or a second opinion.

Nelson Plaza Clinic is focused on providing the best care to you, from the most appropriate clinician.

To provide this level of integrated quality care, it is essential that your health care team know as much as possible about your existing (and past) health and lifestyle. As such all clinicians involved with your care will have access to your record.

If there are any questions you would rather not answer, please leave them blank.

Do you have any personal or family history of:	Nominate if self or family e.g. mother, father, paternal/maternal grandmother etc				Nominate if self or family e.g. mother, father, paternal/maternal grandmother etc			
Diabetes					Colon Cancer			
Hypertension					Depression			
Heart Disease					Breast Cancer			
Stroke					Other Diseases			
Is your mother alive?	Yes	No	Age at death:		Cause of death:			
Is your father alive?	Yes	No	Age at death:		Cause of death:			
Are you an Elite Athlete?	Yes	No	Sport:		Do you have a carer?		Yes	No
What is your Marital Status?								
Any known allergies to medication?								
What social / exercise activities do you engage in and how often?								
What previous occupations have you had?								
Do you have any chronic diseases? (please list)								
Do you currently drink alcohol? Yes No	About how many days of the week do you drink?					How many each day?		
	1	2	3	4	5	6	7	1 2-3 4-6 7 or more
Prior to current alcohol consumption	Nil	Occasional	Moderate	Heavy	Year started		Year stopped	
Do you currently smoke?	Yes	No	About how many cigarettes per day?					
Prior to current smoking activity	Nil	Light	Moderate	Heavy	Year started		Year stopped	
How many different prescription drugs do you take?	Please bring in all your medication packaging stating drug type and dose							
What over the counter drugs do you take? (Please list the drug and dosage)								

I acknowledge that the information provided on this registration and information form is correct to the best of my knowledge.

Patient Name: _____

Signature: _____ (Self / Guardian) Date: _____

**Agreement between the Patient and all Health Care Providers
at Nelson Plaza Clinic (NPC)**

Privacy: I have read and understood the NPC's Privacy and Security of Personal Health Information Brochure. I understand that all health care providers who provide me treatment at NPC will have access to my medical record, unless otherwise arranged. "Health Care Providers" includes all doctors and allied health professionals.

Results of Tests I understand that it is my responsibility to return to NPC to discuss all test results with NPC staff or a doctor. If a follow up appointment with the doctor who requested the test is not convenient, I can return to NPC at any time during opening hours, within three weeks of the test, to be seen by the duty doctor. **Results will not be discussed by telephone.**

Referrals: I understand that it is my responsibility to notify my health care provider at NPC if I do not or cannot see a specialist or hospital to whom I have been referred, or, get a test performed, such as a pathology or radiology test, that has been requested by my health care provider.

Billing: I understand that:

- The billing policy of the health practitioners at NPC may change from time to time.
- If an account is issued, it must be settled at the time of consultation. Failure to do so will incur an administration fee.

Contact Details: I understand how important it is to keep my contact details up to date and will inform NPC immediately of any changes to my contact details.

Failure to Attend: I understand that if I do not attend for a booked appointment without notifying NPC in advance, I may be charged a fee.

Drug Seeking: I understand that if I am prescribed or wish to be prescribed any drugs of addiction, (such as opiates and benzodiazepines), my health care provider or staff member may take whatever action is necessary to verify my prescribed drug history and I consent to this action. This may include, but is not limited to, contacting the doctor shopper hotline, pharmacies, other doctors and the PBS. This check is performed to ensure drugs of addiction are not abused.

Abusive behavior towards staff will not be tolerated.

Date:

Patient Name: _____

Signed: _____ (Patient / Guardian)

Signed: _____ (NPC Staff Member)