Patient Registration Form

EXCELLA MEDICAL CENTRE
NUNDAH

Excella Medical Centre-Nundah is committed to provide our patients with quality health care. To achieve this, it is essential that your health record is kept up to date and accurate. It's your responsibility to advise us of any future contact details change, so we can keep your records updated.

PART A (PATIENT INFORMATION & CONTACTS):

Title	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other:
Surname	
First Name	
Date of Birth	
Gender	☐ Male ☐ Female ☐ Other
Residential Address	
Postal Address (if different to street address)	

Mobile Phone:	**Work Phone:**	**Home Phone:**	
Email			
Occupation			
Medicare Card Number	**Ref No:**	**Expiry Date**	
DVA Card (Gold / White) Number		**Expiry Date**	
If white DVA card, conditions are			
Pension/HCC Card Number		**Expiry Date**	
Next of Kin: (Name, Address & Telephone number) **Relationship to Patient**			
Emergency Contact: *(If different to Next of Kin)*	(Name and Telephone number of the person we can contact if needed)		

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Australian, non-indigenous

☐ Other: Please specify (e.g. Chinese, Indian, British, etc.)……

I confirm there is no other information that I am aware of that would influence the medical treatment /advice to be provided.

Signature: …… **Date: ..... / ..... / .....**

Please hand-over filled Part A to the Front Desk staff so they can create your file while you proceed with PART B.

PART B (PRACTICE POLICY AGREEMENT)

By becoming a patient of Excella Medical Centre-Nundah and signing below I have read and agreed to the following:

- Standard appointments are 10 minutes and generally cover one health concern. If you have complex health issues to discuss or require a longer appointment for any reason you need to either book a separate or a long appointment (Long appointment fee applies)
- A separate appointment must be made per person/family member.
- If you wish to cancel or change your appointment time, please notify us not later than 3 hours prior to the appointment time, so we can offer the vacant spot to another patient. Change or cancellation of an appointment made for the first 3 hours of the day needs to be done by the end of the business day before the appointment day. Appointment made online can be rescheduled or cancelled online (subject to above cancellation policy) without a need to contact the practice. Appointment Non-attendance or Late cancellation will incur a fee ($30 for short and standard appointments and $60 for long appointments), invoiced to you directly. Payment is required prior to any further appointment request. This fee is not Medicare rebateable. This fee can only be waived, if due to severity of your clinical condition, you had to attend emergency department at a local hospital, earlier than your appointment, on the appointment day. Evidence such as discharge summary from the emergency department with admission date and time is needed.
- No service is provided via phone and emails requesting any service will not be responded. An appointment must be made with a doctor for ANY service required including obtaining results, lost or misplaced documents, repeat prescriptions, referrals, filling forms, etc. Results will not be given via email or over the phone.
- Patients who are late to their appointment (less than 10 minutes late) might be seen (at the doctor's discretion) may have to wait until other patients who arrived on time are seen. There is no guarantee if they will be seen.
- Patients who are late to their appointment (more than 10 minutes late) will not be seen and need to reschedule the appointment altogether. A Non-Attendance fee (as per practice cancellation policy) will incur as well. Payment is required prior to any further appointment request.
- Doctors at this practice do not prescribe schedule 8 drugs and have a no tolerance policy to doctor shoppers and drug seekers. Doctors have the right to refuse the request of prescription drugs.
- This practice has a no-tolerance policy to aggressive or abusive behavior. Patients who are physically or verbally aggressive to staff will be banned indefinitely from the practice [at the discretion of the doctor or practice manager].
- It is at the discretion of the doctor and practice staff to provide personal health information to parents/guardians of patients under the age of 16. All patients 16 and over are considered adults and information will not be disclosed to parents/guardians/friends/spouse without permission from the patient.

☐ I have read Excella Medical Centre-Nundah "Patient information sheet" and agree with its terms and conditions.

Name of Patient or Parent /Guardian (if under 16) (please print):

.....

Signature of Patient: .....

Date : .....

OFFICE USE ONLY - DATE ENTERED: **ENTERED BY:**

PART C (PATIENT MEDICAL HISTORY):

We require you to provide us with your medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs.

NAME:_____

ALLERGIES – please list any allergies or sensitivity, in particular medications or dressings. If you do not have any allergies, please write NIL.

Allergies	**Reaction**

PREVIOUS MEDICAL HISTORY: Please list any serious illnesses, operations or hospital admissions:

YEAR	**DETAILS**

HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING (currently or in the past)**? YES / NO** (Please circle relevant conditions)

Blood Pressure/Cholesterol	Schizophrenia / Bipolar
Diabetes/Thyroid	Heartburn / Acid reflux / Ulcer Bowel / Polyps
Any type of Cancer	Stroke / epilepsy / Meningitis
Hepatitis B / Hepatitis C / HIV	Dementia / Pinched nerve
Asthma/ Pneumonia / Bronchitis	Leg clots / varicose veins
Emphysema / Blood Clot	Blocked blood vessel
Depression / Anxiety / Panic	Broken Bones / Fractures
Heart attack / Angina	Glaucoma / Cataract
Palpitations / Heart failure	Hearing Loss / Tinnitus / Vertigo
Arthritis / Osteoporosis	Melanoma / Cysts
Rheumatoid arthritis	Acne / Dermatitis / Eczema
Menstrual Problems / Ovary infection	Erectile Dysfunction / Premature ejaculation / Cysts

FEMALE PATIENTS: WHEN WAS YOUR LAST **PAP SMEAR?**_____/_____/_____**MAMMOGRAM?**_____

CURRENT MEDICATIONS – please list any tablets / injections or inhalers you are taking and if applicable include the "pill" and natural remedies. If you are not currently taking any medications, please write NIL.

Medication	**Dose if known**

FAMILY HISTORY – Has anyone in your close family suffered from the following?

Disease	**Who**	**What age**	**Disease**	**Who**	**What age**
Heart Disease			Thyroid Disease		
High Blood Pressure			Osteoporosis		
Stroke			Cancer		
Blood Clots			Rheumatoid Arthritis		
Diabetes			Mental Illness		

SOCIAL HISTORY:

Marital Status: Single / Married / De-facto / Divorced / Widowed / Separated

	No. Per day	**Year commenced**	**Year (if) Quit**	**Type** (if applicable)
Alcohol				
Tobacco/Cigarette				
Recreational substances?				

I confirm there is no other information that I am aware of that would influence the medical treatment /advice to be provided.

Signature: …….. **Date: ..... / ..... / .....**