Southern Doctors Clinic
383 Canterbury Road
Campsie, NSW 2194
Tel: (02) 9789 5955
Fax: (02) 9718 5326
www.sdccampsie.com.au

New Patient Registration Form

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other: _____

Surname: _____ **First Name** _____

DOB: ____ / ____ / _____ **Gender**: ☐ Male ☐ Female ☐ Other: _____

Ethnicity: ☐ Australian/NZ ☐ Aboriginal ☐ Torres Strait Islander ☐ Other: _____

Languages spoken other than English: _____

Address: _____

_____**Suburb**: _____ **Postcode** _____

Mobile: _____ **Home**: _____ **Work**: _____

Email address:_____

Medicare/ DVA Card Number: __ __ __ __ __ __ __ __ __ __ **Ref**: _____ **Expiry**:_____/_____

Pension/HCC/DVA number: _____ **Expiry**: _____ / _____

Emergency Contact First Name: _____ **Surname** _____

Emergency Contact Number: _____ **Relationship** _____

Next of Kin Name:_____ **Relationship**_____

Contact number:_____

**Please complete and return the first 2 pages to reception.*
**Please complete and return the medical information pages to your General Practitioner.*

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Patient Consent for Practice Communications

Please read carefully prior to signing.

This form seeks your permission for using and sharing your personal information (including health details) regarding our practice's reminders and notifications systems. Our clinic is dedicated to providing quality healthcare and employs technology for communication via SMS and email.

Under Privacy Act 1988 (Cth), Australian Privacy Principles (APPs), and health records laws, we're obliged to inform you about the use and disclosure of your personal information, including health data. Feel free to request our privacy policy from reception for more details on how we handle personal and health information.

Among other communications, we may send you:

1. **SMS appointment reminders**: These notify and confirm upcoming appointments.
2. **SMS clinical communications**: Messages about your clinical care, e.g., pathology results and reminders.
3. **Emailed clinical communications**: Information about clinical care, like referrals.
4. **Emailed health awareness**: General health info, clinic hour changes, and services.

To secure your privacy, we encrypt or protect your data in our systems. Note, however, that unencrypted emails aren't secure and might be intercepted. Consider the risks before using unsecure email:

- Southern Doctors Clinic's emails aren't encrypted.
- Third parties could intercept personal health information.
- Unsecure emails could be forwarded to unintended recipients.
- Employers and service providers might review emails.
- Shared info might be stored in multiple places.

As part of healthcare provision, we'll send you reminders and communications via the listed methods. We might use third-party services (possibly outside your area) for this. We'll aim to use your preferred contact method but might use any provided contact details.

Acknowledgements and Consent

I acknowledge and agree that, in course of providing health care services to me, Southern Doctors Clinic may need to use and disclose my personal information (including any health information) as set out in this form. I acknowledge that that practice will use contact details provided by me (and updated by me) to communicate with me. To the extent that the contact details I have provided to Southern Doctors Clinic are utilised by anyone other than myself, I understand and consent that all communication will be directed to the contact details provided.

Please complete and sign below if you understand and agree to the acknowledgments and consent as set our above.

Patient Name: _____

Parent/Guardian Name (if patient under 16): _____

Signature: _____ Date: _____ / _____ / _____

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General Medical Information

Patient Name: _____ **DOB**: _____ / _____ / _____

Allergies: ☐ Nil known

Allergy/intolerances	Reaction	Severity

Please tick any relevant past medical history / surgical history

☐ Heart Disease	☐ Asthma	☐ High Blood Pressure
☐ Cancer	☐ Migraine	☐ Stomach or Duodenal ulcer
☐ Stroke	☐ High Cholesterol	☐ Blood clots
☐ Epilepsy	☐ Depression/Anxiety	☐ Diabetes

Other illness/surgery:

_____

Current Medications

Medication Name	Dosage

Immunisations:

☐ Pneumococcal ☐ Influenza ☐ Tetanus ☐ Childhood vaccines up to date ☐ Covid

☐ Other:_____

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Family History

	Question	Yes	No
1.	Have any of your close relatives had heart disease before 60 years of age?		
2.	Have any of your close relatives had diabetes?		
3.	Do you have any close relatives who had melanoma?		
4.	Have any of your close relatives had bowel cancer before 55 years of age?		
5.	Do you have more than one relative on the same side of the family who had bowel cancer at any age?		
6.	Have any of your close relatives had breast cancer before 50 years of age?		
7.	Do you have more than one relative on the same side of your family who has had breast cancer at any stage?		
8.	Have any of your close female relatives had ovarian cancer?		
9.	Have any of your close male relatives had prostate cancer before 60 years of age?		
10.	Is there a history of mood disorder in your immediate family?		

If there is a family history of cancer, please specify what kind: _____

Lifestyle Health History

Smoking history

□ Never smoked

□ Former smoker, quit date_____ /_____

□ Current smoker_____/day

Number of years smoking: _____

Alcohol consumption history

Do you drink alcohol: □ yes □ no

Drinks per day:_____

Drinks per week:_____

Women's Health: Last cervical screening test (pap) date: _____ / _____

Last mammogram date: _____/_____

Men's Health: Last Prostate check (if aged over 40) _____/ _____

INFANT PROFILE

Please list any problem during pregnancy_____
When was the baby born: □ Full term □ Premature – how many weeks? _____
Mode of delivery: □ Normal □ Caesarean □ Forceps □ Vacuum extraction
Please list any health problems for the baby after birth _____
Feeding: □ Bottle □ Breast fed
Are there any smokers in the household? □ Yes □ No