CAIRNS HEALTH COLLECTIVE

NEW PATIENT REGISTRATION FORM

Preferred Title:	☐ Mr ☐Mrs ☐Master ☐Miss ☐Dr ☐Prof		
Name			
Date of Birth			
Sex at Birth	☐ Female ☐ Male		
Gender Identity	☐ Female ☐ Male ☐ non-binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs		
Nationality			
Do you identify as	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander		
Street Address			
Postal Address			
Mobile	**Home**	**Work**	
Occupation	**Employer**		
Email Address			
Medicare Number		**IRN**	**Expiry Date**
DVA Gold / White			**Expiry Date**
Pension Card **Health Care Card**			**Expiry Date**
Next of Kin	**Name**		**Relationship**
	Phone number		
Emergency Contact	**Name**		**Relationship**
	Phone number		
Height:	**Weight:**		
Allergies: ☐**NO** ☐ **YES** (If yes, please list and if severe or mild)			
☐ **Non-smoker** ☐ **Smoker** ☐ **Ex- Smoker** How many cigarettes per day? _____Year started: _____Year quit: _____			
Alcohol: How many days per week? _____ How many drinks per day? _____			
Significant family history: _____ _____ ☐ No significant family history ☐ Unknown (e.g. Adopted)			

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Cairns Health Collective participates in Quality Improvement Activities. This involves the sending of de-identified information for health data analysis. Please inform reception if you do not wish to participate.

Privacy

Your medical record is a confidential document. It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff. Please refer to our Privacy Policy located at Reception or via our website.

Do you consent to the Doctors at Cairns Health Collective uploading and accessing your My Health Record?

☐ Yes ☐ No

Do you consent to receive SMS from your GP or Cairns Health Collective regarding your appointments?

Appointment reminders	☐ Yes	☐ No
Clinical Reminders	☐ Yes	☐ No
Clinical Communications (Results & Clinical Messages)	☐ Yes	☐ No
Health Awareness (Leaflets & Database)	☐ Yes	☐ No

Do you consent to the Staff at Cairns Health Collective sending non secure emails to you and service providers which may contain private/clinical information?

☐ **Yes** ☐ **No**

Please note that doctors at this practice use AI technology to assist with clinical note-taking (scribing). This allows your doctor to focus more on you during consultations. By signing this form, you consent to the use of A1 in your treatment, in accordance with our Privacy guidelines. Please speak to your doctor if you have any questions or concerns.

Signature: _____ **Date:** _____

Photo ID sighted ☐ Staff Signed: _____