Name _____

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 arees 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, uncle etc		Nominate if self or family e.g. mother, father, uncle 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	
What is your Marital Status?		What is your sexuality?	
Are you an Elite Athlete?	Yes No Sport?	Do you have a carer?	Yes No
What social / exercise activities do you engage in and how often?			
What previous occupations have you had?			

Do you currently drink alcohol? Yes No	How many each day? 1 2-3 4-6 7 or more				About how many days of the week do you drink? 1 2 3 4 5 6 7			
Prior to current alcohol consumption	Nil Light 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 mediation 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.

Your Signature: _____ Date: _____

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 No		No	
Surname		Medicare Expiry			
First Name		Pension / HCC No		Exp	
Middle Name		Card Type			
Preferred Name		DVA No and colour		Gold White	
Date of Birth		Safety Net No			
Sex	Male Female	Record No		Office Use Only	
Ethnicity		Do you have a regular GP?	☐ Yes ☐ No		

Do you have any chronic disease/s?
(please list)

Do you wish to be recognised as an Aboriginal Torres Strait Islander Neither (please circle)

Address Line 1			Usual account		Office Use Only	
Address Line 2			Health Fund			
Suburb		Postcode	Fund No		Exp	
Home Phone			Mobile			
Work Phone			Religion (optional)			
Email			Current Occupation			

I wish to receive the practice newsletter by email ☐ Yes ☐ No

If we need to contact you, please circle where we may leave a message.
(To ensure your privacy, we will only identify the surgery name and who to contact – NOT what we wish to speak to you about)

Home Phone	Work Phone	Email
Mobile	SMS	

Authorised People (optional): I authorise the following person to act on my behalf in regards to access to my records, results and other information that may be held by the surgery. I understand I can revoke this authority at any time by contacting the surgery in writing.

Contact Person :_____ _____ Relationship to you: _____

Contact Details: Ph:_____Mobile: _____Email: _____

Signed: _____ _____ **(Self or Guardian)** **Date:** _____

Agreement between _____ and all health care providers at Nelson Plaza Clinic (NPC)

Privacy: I have read and understood the NPC's Privacy Policy. I understand that all health care providers 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 must return to NPC at any time during opening hours, within three weeks of the test, to be seen by the duty doctor. All appointments dealing only with test results will be bulk billed. "Test" includes all pathology (e.g. blood, urine, swabs) Histology (e.g. biopsies, pap smears), Radiology (e.g. X-rays, Ultrasounds, CT Scans). 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:

- ☐ Bulk billing, if offered, is a privilege which may be withdrawn if I do not reasonably participate in the management of my health.
- ☐ The billing policy of the health practitioners at NPC may change from time to time.
- ☐ All accounts must be settled at the time of consultation. Failure to do so will incur an administration fee.

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 behaviour: Abusive behaviour towards staff will not be tolerated.

Date:

Signed _____ (Patient)

Signed _____ (NPC Staff Member)