New Patient Registration 新病人登记表

PATIENT DETAILS 病人细节			
Title 称呼：	□ Mr先生 □ Mrs夫人 □ Ms小姐/女孩 □ Miss小姐/女孩 □ Master小朋友/男孩□ Dr 医生 □ Other (specify):		
First name 名:		**Middle name(s) 中间名:**	
Surname 姓:		**Date of Birth 出生年月:**	
Preferred name 喜欢被称呼的名字 (if different):		**Previous names 以前的名字 (if any) 如果有的话:**	
Country of Birth 出生国家:	☐ Australia - 澳大利亚 ☐ Other 其他 (specify) 指定:	**Gender 性别:**	☐ Male男性 ☐ Other其他 ☐ Female女性
Cultural background 种族背景(can specify multiple 可以指定多个):	☐ Australian澳大利亚人,不属原住民 ☐ Other(s)其他 (specify 指定):	**First language 第一语言:**	☐ English英语 ☐ Other其他 (specify指定):
Occupation 职业 (if retired, also specify former 如果退休，还需注明之前的工作):		**Do you need an interpreter 你是否需要翻译员?**	□ Yes 有 □ No无
Do you identify as? 你属于?	□ Aboriginal原住民, 但不属太平洋岛民 □ Torres Strait Islander太平洋岛民,但不属 原住民 □ Both 原住民和太平洋岛民 □ Neither其他, 请注明		
Marital status 婚姻状况:	□ Single 单身 □ Married 已婚 □ Defacto 同居关系 □ Divorced 离婚 □ Separated 分开的 □ Widowed 寡		
CONTACT DETAILS 联系方式			
Street and number 街道号码:			
Suburb 区:		**Postcode 区邮编:**	
Mobile phone 手机电话:		**Other phone 住家电话/工作电话:**	
Email address 电子邮件:			

MEDICARE, CONCESSION AND PRIVATE HEALTH INSURANCE 澳大利亚联邦医疗保健卡，优惠卡和私人保险			
Do you have a Medicare card? If so, please give it to Reception 你有澳大利亚联邦医疗保健卡吗？有的话请给接待处。 并填写联邦医疗保险号码 (包括保险人的号码和过期日期) **If you don't have a card or don't have the card (or the number) with you, please give a photo ID to Reception instead** **如果没有澳大利亚联邦医疗保健卡（卡号）的话， 请将您的带有照片的证件拿给前台。**		☐ Yes 有. Medicare Card Number卡号 个人代码 Ref. No.: 有效期限 Expiry： _____ ☐ Yes 有, but not on me但不是在我身上 ☐ No无, but I expect to get one但我希望得到一个 ☐ No无, I'm not entitled to one我无权获得	
Do you have a concession card (Pensioner Concession card, Health Care Card, Seniors Health Care Card, or DVA card)? 您有优惠卡（养老金卡/健康卡/老年卡/DVA卡）吗? 号码和过期日期：		☐ Yes 有– please give to Reception请给接待处 ☐ No 无	
Do you have Private Health Insurance? 你有私人健康保险吗？	☐ Yes 有 ☐ No无	**Insurer name** 保险公司名称：	

MEDICAL HISTORY 病史			
Measurement 测量：	**Height 高度：**		**Weight 重量:**
Do you have any allergies? 你有过敏史吗?	☐ Yes有– provide details 提供详细的信息 ☐ Medication 药物过敏史 ☐ Other 其他 ☐ No 无	**What to?** 如有，对什么 ？	
		Describe reaction: 请描述反应	
Do you currently or have you ever suffered from any of these medical conditions (Tick all that apply, and give details as applicable) 您目前或曾经患有这些疾病中的任何一种吗？ （勾选所有适用项，并在适用时提供详细信息）	☐ Asthma 哮喘 ☐ Stroke中风 ☐ Blood clots 凝血 ☐ Arthritis 关节炎 ☐ Osteoporosis 骨质疏松症 ☐ Dementia 老年痴呆 ☐ Anxiety 焦虑 ☐ Depression抑郁症	☐ Heart disease心脏病 ☐ High blood pressure高血压 ☐ Coeliac disease 乳糜泄 ☐ Peptic ulcer 消化性溃疡 ☐ Gout 痛风 ☐ Psoriasis 银屑病 ☐ Seizures or fits 癫痫 (羊癫疯)? ☐ Schizophrenia 精神分裂症	☐ Diabetes糖尿病 ☐ High cholesterol 高胆固 ☐ Glaucoma 青光眼 ☐ Hepatitis 肝炎 ☐ Anaemia 贫血 ☐ Emphysema 肺气肿 ☐ Migraine 偏头痛 ☐ Abnormal pap smear子宫颈抹片异常
	☐ Cancer? 癌症 Please specify type什么癌症: ☐ Other major conditions? Please specify 还有其他的病史吗？有的话请说明？		
Do you have any family history of the above conditions? 您有以上疾病的家族史吗?	☐ Yes有– details: ☐ No 无	**Condition 状况：**	**Relationship 关系:**
Have you had any operations?	☐ Yes有 – provide details:		

您曾经有没有做过手术?	□ No 无
Are you taking any prescription medications 您在服用任何处方药吗？	□ Yes有– Please list (or attach) 请列出（或附上） □ No 无
Are you taking part in a clinical trial 您正在参加临床试验吗？	□ Yes 有 – provide details 提供详细信息: □ No 无
Any over-the-counter meds, herbals, vitamins, supplements, etc? 您在食用任何非处方药、草药、维生素、补充剂等吗?	□ Yes有 Please list请列出: □ No无
Immunisation history 疫苗史	

***Bring child's immunisation book** 带上孩子的疫苗书

Do you smoke 吸烟状况? (incl vaping 包括电子烟）	□ Never 从未 □ Yes 有– complete details below 完整的细节如下 □ Former 以前 – complete details below 完整的细节如下				
Year started 哪年开始?		**Year quit哪年戒烟?**		**How much do/did you smoke per day (on average)? 平均每天吸多少烟**	_____cigarettes 香烟
Do you drink alcohol 你饮酒吗?	□ Never 绝不 □ Yes 有– □ Former 以前	**If Yes, how many standard drinks do you have on the days you do drink (on average)?** 如果有的话，平均一天多少杯?	____drinks	**Do you ever drink 6 or more standard drinks in one occasion?** 你曾经有一次喝过 6 杯或更多酒吗？	□ No 无 □ Monthly or less每月或更少 □ 2-4 times / month 2-4次/月 □ 2-3 times / week 2-3 次/周 □ 4+ times / week 4+ 次/周
Do you take illicit drugs? 你服用非法药物吗？	□ Never 从未 □ Occasionally 偶尔 □ Weekly 每周			**If yes 有, what kind 哪一种？**	

WOMEN'S HEALTH 女性健康–COMPLETE ONLY IF FEMALE & AGED 16 YEARS OR OVER 仅当女性且年满 16 岁或以上时填写

When was last pap smear 上一次子宫颈抹片检查是什么时候？		**Last pap smear result** 上次子宫颈抹片检查结果：	□ Normal 正常结果 □ Abnormal 不正常 □ Unsure 不确定
When was your last mammogram		**Family history of breast cancer 乳腺癌家族史:**	□ Mother 母亲 □ Sister 姐姐妹妹 □ Other 其他 □ No 无

EMERGENCY CONTACT 紧急联络人电话 / NEXT OF KIN直系亲属			
Would you like to nominate an Emergency Contact (eg. partner/relative/friend) ? 紧急联络人电话（例如 家人/亲戚/朋友）?			□ Yes 有– specify below 在下面指定 □ No 无
Name 姓名:		**Phone 电话号码:**	
Address地址(if different to patient):		**Relationship to patient** 与患者的关系：	
Is the above Emergency Contact also the Patient's Next of Kin 上述紧急联系人是否也是患者的近亲 ?		□ Yes有 □ No无– please specify Next of Kin below	
Name 名称:		**Phone** 电话:	
Address 地址**(if different to patient)**（如果与患者不同）:		**Relationship to patient** 与患者的关系:	

PREFERENCES 喜好	
Do you consent to receiving SMS reminders of appointments and when it is time for routine preventative health measures (eg. vaccinations, health assessments, pap smears) 您是否同意接收关于定期检查的短信提醒（例如疫苗接种、身体健康评估、宫颈检查）?	□ Yes需要 □ No 不需要
How did you first find out about us 您最初是如何知道我们的 ?	☐ I was a patient at the Doctor's previous practice 我是医生以前诊所的病人 ☐ Friend/Family 朋友/家人介绍 □ Pharmacy 药店人员 □ Other Health Professional 其他卫生专业人员 □ Internet *互联网* (specify) 例如 □ HealthEngine 健康引擎 □ HotDoc 预约网站 □ Google 谷歌 □ Facebook 脸谱 Other 其他? (please specify 请明确说明):

你上一次乳房 **X** 光检查是什么时候?			
Are you? 你现在的情况是 ?	□ Pregnant 怀孕 □ Breastfeeding 哺乳 □ None 没有任何 □ Hoping to conceive in next 12 months 希望在未来 **12** 个月内受孕		

PRIVACY POLICY 隐私政策 :

We will collect, store, use and disclose the above information and any other personal information we collect about you in accordance with our Privacy Policy. This is available on our website at https://www.springvalesouthmedical.com.au/blank-page, or please ask our Receptionist for a copy. 我们 将会 收集、存储、使用和披露上述信息以及我们收集到的有关您的其他个人信息。这可以在我们的网站 https://www.springvalesouthmedical.com.au/blank-page 上找到，或者你可以向我们的接待员索取副本

Patient's Name 病人 **姓名 & Signature** 签名:		**Date** 日期:	_____/_____/20___
Parent's 父母**/ Guardian's** 监护人 **Name / Signature** 签名 :		**Date** 日期:	_____/_____/20___

Health Information Collection and Use Consent Form 健康信息收集和使用同意书

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

作为我们医疗实践的患者，我们要求您向我们提供您的个人详细信息和完整的病史，以便我们可以正确评估、诊断、治疗并积极满足您的医疗保健需求。

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.
我们的宗旨是保护您的健康信息的隐私和安全存储。您可以索取我们的隐私政策副本，其中包括有关收集、使用和披露您的健康信息的信息。

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below. 我们需要您的同意才能收集有关您的个人信息并通过以下方式使用您提供的信息。请仔细阅读本同意书，并在下方注明的地方签名

- Administrative purposes in running our medical practice. 运行我们的医疗实践的行政目的
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements. (DB4 - I assign my rights to benefits to the provider who rendered the services) 计费目的，包括遵守医疗保险和健康保险委员会的要求。（**DB4 - 我将我的利益分配给提供服务的提供者**）
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals. 向参与您的医疗保健的其他人披露，包括在此医疗实践之外的治疗医生和专家。这可能会发生在转诊给其他医生或进行医学检查以及转诊后返回给我们的报告或结果中
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching. 出于患者护理和教学的目的，向实践中的其他医生、与实践相关的场所等披露
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement. 用于研究和质量保证活动，以改进个人和社区卫生保健和实践管理。通常使用无法识别您身份的信息，但如果需要可以识别您身份的信息，您将被告知并有机会"选择退出"任何参与
- To comply with any legislative or regulatory requirements eg notifiable diseases. 遵守任何立法或监管要求，例如法定疾病
- For reminder letters which may be sent to you regarding your health care and management. 可能会发送给您的关于您的医疗保健和管理的提醒信
- You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you 您可以拒绝以上述所有或部分方式使用您的健康信息，但这可能会影响我们管理您的医疗保健以为您提供最佳结果的能力

I have read the information above and understand the reasons why my information must be collected 我已阅读上述信息并了解收集我的信息的原因.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me 我明白我没有义务提供任何要求我提供的信息，但不这样做可能会影响向我提供的医疗保健和治疗的质量.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances 我知道我有权访问收集到的关于我的信息，除非在某些情况下可以合法地拒绝访问。在这些情况下，我将得到解释.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained 我明白 如果我的信息被用于上述以外的任何其他目的，将获得我的进一步同意.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice 我同意通过出于上述目的的做法处理我的信息， 但受我通知此做法的任何访问或披露限制.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign 我不确定，并希望在签署之前与诊所中的某个人进一步讨论.	☐

Patients Name 病人姓名 _____ Date 日期 _____/_____/_____

Patient's signature 病人 签名 _____

Signed as Guardian for child 签署为孩子的监护人 _____

Full Name (全名) _____