VIBE NATURAL HEALTH
NEW PATIENT REGISTRATION AND CONSENT FORM

We collect this information to help us provide you with safe, high-quality care.
This form complies with the RACGP Standards for General Practices and the Privacy Act 1988 (Cth). Your personal health information is kept private and secure in line with federal and state privacy laws. If you have any concerns, you may leave a section blank and discuss it directly with your GP.
Please notify us of any changes to your contact details. Accurate contact information ensures we can identify your records correctly and contact you promptly about test results, recalls, or other health matters.

PERSONAL DETAILS:

Title	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other:						
First Name				Middle Name			
Last Name				Preferred Name			
Date of Birth	/ /			Birth Sex	☐ Male ☐ Female ☐ Other		
Marital Status	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed						
Residential Address							
Suburb				Postcode		State	
Postal Address							
Phone Number	Home:		Mobile:			Work:	
Email							
Contact Method	☐ Email ☐ Home Phone ☐ Mobile Phone ☐ Work Phone						
Occupation							
Emergency Contact		Relation		Phone			
Next Of Kin		Relation		Phone			
Do you have an advance health directive for end of life care		☐ Yes ☐ No *For more information talk to your GP*					

Medicare No.		Position on card		Expiry	
DVA No.		☐ White ☐ Gold		Expiry	
Pension/Health Care Card No.				Expiry	

CULTUTAL BACKGROUND:

Ethnicity	☐ Australian ☐ Other (please specify):				
Are you Aboriginal or Torres Strait Islander origin	☐ No ☐ Aboriginal ☐ Torres Strait Island ☐ Aboriginal & Torres Strait Island				
Is English your first language	☐ Yes ☐ No	If not, do you require an interpreter	☐ Yes ☐ No	If yes, Specify Language	

YOUR HEALTH HISTORY

Do you have any known allergies or adverse reactions? ☐ NO ☐ Yes – Please specify Below:

List any known allergies and intolerances to medications	Describe your reaction

Do you take any regular medications or Complementary medicines? ☐ NO ☐ Yes – Please specify name and doses:

Family Medical History

Do any close family members (parents, siblings, children) have a history of any of the following?

☐ No known family history ☐ Diabetes ☐ Heart disease ☐ Mental health conditions

☐ Stroke ☐ High blood pressure

☐ Cancer (please specify type): _____ ☐ Other (please specify): _____

Immunisation History

Are your immunisations up to date? ☐ Yes ☐ No ☐ Unsure

Please list any recent or significant immunisations (e.g. COVID-19, influenza, tetanus, childhood vaccines):

CONSENT:

Do you consent to being contacted by SMS and/or email with recalls, test reminders, and general health reminders to support your ongoing care? (No health information Included in SMS)	☐ Yes	☐ No
Our practice also sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders,which can be helpful if you move	☐ Yes	☐ No
Do you consent to receive updates, service info, and promotions from us and approved partners? You can unsubscribe anytime.	☐ Yes	☐ No

PARENT OR GAURDIAN DETAILS (Please complete this section if child is under 17 years of age):

Title		First Name		Middle Name			
Last Name				Preferred Name			
Date of Birth	/ /			Birth Sex			
Phone				Relationship			
Medicare No				Position on card		Expiry	

PRIVACY AND CONFIDENTIALITY STATEMENT

Vibe Natural Health complies with the Privacy Act 1988 (Cth), Australian Privacy Principles, and RACGP Standards (5th Edition). We collect and use your personal and health information to support the delivery of safe, effective care. This includes managing your medical record, appointments, pathology, recalls, legal obligations, communication with you, and coordination with other providers. De-identified data may be used for training or research purposes.

We do **not** upload your information to **My Health Record** by default. If you would like specific records uploaded, please speak directly with your practitioner — we will only do so with your clear consent.

Your information is stored securely and accessed only by authorised staff or trusted third-party providers as needed for your care. By signing this form, you acknowledge our privacy practices and consent to the use and sharing of your information as outlined. If your consultation is bulk billed, you agree to assign your Medicare benefits to the treating practitioner.

To view our full Privacy Policy, please speak with reception or visit www.vibenaturalhealth.com.au.

I, _____, understand and consent to the above Privacy Statement.

Signed: _____ Date: _____

Transferring Your Health Records

If you've previously seen a GP at another clinic, your health records from that practice may help us provide better, safer care. You are welcome to request a copy or summary of your records be transferred to us. Please ask reception for more information on how to arrange this.

Keeping Your Details Up to Date

Please let us know if your contact details or Medicare information change, so we can keep your records accurate and stay in touch about your care.

HOW DID YOU FIND ABOUT US?

☐ Word of Mouth ☐ Google ☐ Referred by another practitioner (please specify): _____

☐ Street Signage ☐ Social Media

PLEASE RETURN THIS FORM TO RECEPTION ONCE COMPLETED