


PATIENT REGISTRATION FORM-PARKWOOD GREEN MEDICAL

Contact information

Title:	First Name	Family/Surname
Date of Birth:	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified	
Home address:  <input type="checkbox"/> Postal address is same		
Home Phone:	Consent to home phone messages <input type="checkbox"/> No <input type="checkbox"/> Yes	
Mobile Phone:	Consent to SMS appointment reminders <input type="checkbox"/> No <input type="checkbox"/> Yes	
Email Address:		

Healthcare Identifiers

Medicare Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	IRN	Exp date: /
DVA (veterans) File Number										Exp date: /	
Concession/Pensioner Card										Exp date: /	

Cultural Identity, Medical History and BMI

To assist with health initiatives – are you of Aboriginal and/or Torres Strait Islander descent?
 Yes – Aboriginal Yes – Torres Strait Islander Yes – Both No

Country of Birth:

Languages Spoken: _____ Do you require an interpreter service? Yes No

Weight (kg): _____ Height (cm): _____ Allergies: _____

Patient Status

Do you have a MHR (My Health Record) Yes No Unsure

Parent or Carers detail if the patient is **under 12 years** of age – (Leave blank if not applicable)

Name: _____ Relationship to patient: _____
 Gender: _____ Date of Birth: _____

Next of Kin

Name		Relationship to patient:	<input type="text"/>
Home Phone			
Mobile Phone		Work Phone	

Emergency Contact same as next of kin

Name		Relationship to patient:	<input type="text"/>
Home Phone			
Mobile Phone		Work Phone	

PLEASE READ CONFIDENTIALITY STATEMENT ON BACK BEFORE SIGNING

Your Name:	Signature:	Date:
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By signing above, you confirm that you have read and agree to the information provided on the back of this document.

Tel 9449 4100 - Fax 9449 4144 - Email: reception@parkwoodgreenmedical.com.au

New Registration Form - Patient Consent

This medical practice collects information from you for the primary purpose of providing quality health care. 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.

We may use the information you provide, in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclosure to other doctors, allied health workers and nurses who may work in the practice, including Locums and Accreditation Surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

By signing this document, I agree to the following:

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- 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.
- By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access or disclosure that I notify the practice of.
- I consent or decline as indicated to receive an SMS message regarding future appointments
- I consent or decline as indicated to messages being left on telephone message service