

PATIENT REGISTRATION FORM

Contact Information

Title: Mr / Mrs / Miss / Mstr / Ms (circle applicable) Date of Birth: _____

First Name: _____

Surname/Last name: _____

Gender Male Female Unspecified

Address: _____

Mobile phone: _____ Home/work phone: _____

Consent to SMS appointment reminders No Yes

Email: _____

Healthcare Identifiers

| | | | | | | | | | | | | |
|----------------------------|--|--|--|--|--|--|--|--|--|--|---------------|---------------|
| Medicare Number | | | | | | | | | | | 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/Origin of Birth: _____

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

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

Patient Status – DOB required of parent if patient is 16 years and under

| | | | |
|--------------------------|--|--------------------------|----------------|
| Next of Kin | Name and Relationship to patient: | | Date of birth: |
| Mobile Phone | | Work/Home | |
| Emergency Contact | <input type="checkbox"/> same as next of kin | Relationship to patient: | |
| Name | | Home Phone | |
| Mobile Phone | | Work Phone | |

PLEASE READ CONFIDENTIALITY STATEMENT ON BACK BEFORE SIGNING

| | | |
|-------|------------|-------|
| Name: | Signature: | Date: |
|-------|------------|-------|

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

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 pro-active 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