



PATIENT REGISTRATION FORM

Important: Please print this form, fill it out, and bring it with you when visiting the clinic.

SECTION A - PATIENT INFORMATION

Title: Mr | Mrs | Ms | Miss | Mast. | Dr

Surname:

First Name:

Preferred Name:

Date of Birth:

Gender: Male | Female | Other

Address:

Suburb:

State:

Postcode

Home Phone:

Mobile:

Work:

Email:

Do you consent to SMS/Email Reminders: Yes | No

Are you Aboriginal or Torres Strait Islander: Aboriginal | Torres Strait Islander | Aboriginal/Torres Strait | Neither

Country of birth:

Do you require and Interpreter: Yes | No

Language if required:

SECTION B - GOVERNMENT IDENTIFIERS

Medicare Number: _____

Patient Number on Card: ____ Expiry: ____ / ____

Pension Card Number: _____

Expiry: ____ / ____ / ____

Healthcare Card Number: _____

Expiry: ____ / ____ / ____

DVA Number: _____ Colour: _____ Conditions: _____ Expiry: ____ / ____

SECTION C - IN CASE OF EMERGENCY

Next of Kin First Name:

Contact Number:

Surname:

Relationship to patient:

Alternate Contact:

Emergency Contact First

Name: Contact Number:

Relationship to patient:

Surname:

Alternate Contact:



SECTION D – HEALTH INFO COLLECTION AND USE CONSENT FORM

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.

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.

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.

- ☐ Administrative purposes in running our medical practice.
- ☐ Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- ☐ Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- ☐ Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- ☐ 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.
- ☐ To comply with any legislative or regulatory requirements eg notifiable diseases.
- ☐ For reminder letters which may be sent to you regarding your health care and management.

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.

- ☐ I have read the information above and understand the reasons why my information must be collected.
- ☐ 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.
- ☐ 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.
- ☐ 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.
- ☐ 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.

Date: _____

Signed: _____

Signed as Guardian for child: _____ Guardian Name(printed): _____