New Patient Registration Form

Personal Details

Title: Mr ( ) Mast ( ) Mrs ( ) MS ( ) Miss ( ) Dr ( ) Other

Given Name: _____ Middle Name _____ Last Name _____

Preferred Name: _____ D.O.B _____ Gender Male ( ) Female ( ) Other _____

Pronouns: (please circle) She/Her/Hers He/Him/His They/Them/Theirs

Medicare
No._____ Ref No. _____ Exp. Date _____

Postal Address: _____

Home Phone _____ Work Phone_____ Mobile _____

Email _____

Do you wish to identify yourself as an Aboriginal or Torres Strait Islander Yes ( ) No ( ) or any other Cultural Background Yes ( ) No ( )

Concessions

Pension No: _____ HCC _____ Expiry Date_____ DVA _____

Emergency Contact

Next to Kin _____ Relationship _____ Phone _____

Emergency Contact Name _____Relationship_____Phone _____

Ethnicity

Country of Birth _____ Year of Arrival in Australia_____ Ethnicity (Culture, Origin) _____

Spoken Language _____

Health Information

Allergies or Sensitivities? Yes ( ) No ( ) If so, please give details:_____

Medical Conditions or Disabilities Yes ( ) No ( ) _____

Childhood immunisation completed ? Yes ( ) No ( ) Last Tetanus Injection Year _____

Are you an overseas visitor with private health? Yes ( ) No ( ) Private Health Name/Number _____Exp Date_____

At the time of consultation, do you require an interpreter to attend? Yes ( ) No ( ) If so, language required_____

Authorisation

Would you like to receive reminders about periodic health checks, e.g. diabetic reviews, immunisations, pap smears etc. Yes ( ) No ( )
Are you happy for us to send you reminders via SMS? Yes ( ) No ( )

How did you hear about us? ( ) word of mouth ( ) Google ( ) Our Website ( ) Health Engine ( ) Flyer ( ) Other _____

Sign _____ Date: _____

PLEASE TURN OVER AND FILL IN THE BACK PAGE

Health Information 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, Allied Health Professionals 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.
- Disclosure to other doctors in the practice, locums and Allied Health Professionals 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 e.g. 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 understand that depending on the age of my child (16 and over) and given my child's right to privacy, in the clinical judgement of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	☐
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.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

Patient's Name: _____ **Date:** _____

Patient's Signature: _____

Signed as guardian for child: _____ **Name:** (Printed) _____

After-Hours Care: Total GP Care provides 24 hour after-hours care for regular patients via a practice GP. A $550 non-refundable up-front fee applies. Call (08) 8102 0992 to access this service.