

New Patient Registration Form



Title: _____ First Name: _____ Last Name: _____

Preferred Name: _____ DOB: ___/___/___ Occupation: _____

Home Address: _____

Contact Number: _____ Email address: _____

Next of Kin: _____ Relationship: _____ Ph: _____

Do you identify as: Aboriginal Torres Strait Islander Both Neither

Other Cultural Background: _____ Country of Birth: _____

Medicare Number _____ Reference No _____ Expiry ___/___/___

Do you have: Pension Card or Health Care Card: CRN: _____ Expiry ___/___/___

DVA Number: _____ Expiry ___/___/___

OSHC Provider: _____ Member # _____ Expiry ___/___/___

Australian Licence or Passport number(only if overseas health cover): _____

*If the appointment is for a child under 17 years old, for Medicare claiming purposes, we require the parents: Full Name: _____ DOB: ___/___/___ Medicare Card ref: _____

BRIEF MEDICAL BACKGROUND

Do you smoke?

YES How many per day? _____ NO

If you were an ex-smoker, when did you stop? _____

Do you consume alcohol?

YES Occasional NO

How many times a week _____ How many standard drinks per day _____

Do you have any ongoing health problems? YES NO

If yes, please list: _____

Please list all medications you are currently taking: NONE

Please list all Medication allergies you have: NONE

How did you hear about us?: Google, Yellow Pages, Word of Mouth

Mail drop, Other please list: _____

TRANSFER OF HEALTH INFORMATION

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please turn over to sign consent form

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 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.
- 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.

Cancellation Policy: At least **24 hours notice** of cancellation or rescheduling of your appointment is required to allow a reasonable time to fill that appointment time. If you cancel an appointment within 24 hours of your booked appointment you will be charged \$50. The cancellation fee is required to be paid prior to your next scheduled appointment. Our aim is not to charge you, but to allow enough time for us to fill your appointment spot with other clients who are waiting for treatment.

I have read the information above and understand the reasons why my information must be collected & agree to the cancellation policy.

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.

Patients Full Name: _____

Date _____/_____/_____

Patient's signature: _____

Signed as Guardian for child: _____

Name: _____