New Patient Registration Form

Title: Mr / Mrs / Ms / Miss / Master / Dr / Other:		DOB:
Given Name(s):	Surname:	
Preferred Name:	Gender: Male / Female / Other:	
Aboriginal/Torres Strait Islander Identity: Aboriginal / Torres Strait Islander / Both / Neither		
Ethnicity: Australian / Other:	Occupation:	
Address:		
Suburb:	State:	Postcode:
Postal Address:		
Suburb:	State:	Postcode:
Home Ph:	Work Ph:	Mobile Ph:
Are you happy to receive SMS reminders for appointments and recalls: Yes / No		
Email:		
Medicare No.:	Patient No. on Card:	Expiry:
Concession Card Type: Pension Card / Health Care Card / Commonwealth Seniors Card		
Concession Card No.:		Expiry:
Veteran Card No.:	Veteran Card Colour: White / Gold	
Next of Kin Given Name:	Surname:	
Contact No.:	Relationship:	
Emergency Contact Given Name:	Surname:	
Contact No.:	Relationship:	
Past Medical History:		
Medications:		
Allergies:		
I acknowledge account fees and debt recovery expenses will be charged on overdue accounts		
Signed:	Date:	

Payer Details (if other than patient):		
Given Name(s):	Surname:	
DOB:	Gender: Male / Female / Other:	
Address:		
Suburb:	State:	Postcode:
Medicare No.:	Patient No. on Card:	Expiry:

PATIENT INFORMATION AND CONSENT FORM
PRIVACY AND CONFIDENTIALITY

Privacy Amendment (Private Sector) Act 2000
(This Act applies to patients treated after 21 December 2001)

To assist in providing appropriate care and treatment to you as an individual, it is necessary for us to collect and record your personal and health information.

We use this information about you:-

- For communicating relevant information with other treating doctors, specialists or allied health professionals. (Including electronically if appropriate.)
- For follow up reminder/recall notices.
- Accounting/Medicare/Health insurance procedures.
- Quality Assurance activities such as accreditation.
- For disease notification as required by law (eg. Infectious diseases)
- For use by all doctors in this group practice when consulting with you.
- For legal related disclosure as required by a court of law (eg subpoena, court order.)
- For research purposes (de-identified, meaning you are not able to be identified from the information given).

We are happy for you to access personal information we hold about you and if you believe that information is incomplete, incorrect or inaccurate, you may request amendment to it. We request that you apply in advance, in writing, stating precisely what information you require, and if requested, be able to provide proof of identity. Administrative charges for time spent and photocopying costs could apply and patients will be notified in advance of an estimate of these costs.

I ……..…….. have read and understood this information and hereby **CONSENT** to my personal and health information being used in the manner described above.

Signed: ……. Date: …….

I …….. have read and understood this information and hereby **DO NOT CONSENT** to my personal and health information being used in the manner described above.

Signed: …….. Date: …….