

Registration form for new patients

Title Surname First name

Your preferred name Date of birth / /

Birth Sex: Male Female Other Unknown

Gender Identity: Male Female Non binary Gender diverse Transgender

Different Identity

To assist with health initiatives, are you Aboriginal or Torres Strait Islander?

Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander Australian

Do you identify as someone from a different cultural background?

NO YES please elaborate

Address Suburb

Postcode

Home phone Work: Mobile

Email Address

Please note, Email correspondence is not considered a secure source of transmitting health information as it could be intercepted, forwarded or read by someone other than the intended recipient. We will therefore not initiate electronic communications with our patients however upon receipt of incoming electronic correspondence, this will imply the sender has consented to be contacted via email.

Medicare number Line number (Next to name) Exp date.. .../.....

Healthcare card Pension card Number..... Exp date...../...../.....

Veteran affairs number Colour Exp date

Next of Kin.....Emergency Contact.....

Relationship..... Relationship.....

Contact Number Contact Number

Prescriptions preferred via: Paper

SMS **SMS (other number).....**

Email **Email (other address).....**

Do you consent to using SMS as a method of communication to remind you of your appointment? Yes No

Our practice provides our patients with preventative care and early case detection reminders e.g. immunisations, annual health checks and Pap smears etc.

Do you wish to have any relevant reminders sent to you? Yes No

Do you consent to participate in our quality assurance activities and provide your de-identified information for the purpose or research? (Your person information including Name, DOB & Address is NOT shared, only your health information *please note, if you do not wish to participate in the research program, this will not affect the care you receive from our practice*) Yes No

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PATIENT CONSENT AND PRIVACY AGREEMENT

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the [Australian Privacy Principles](#), we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- For legal related disclosures as required by Court of Law;
- For disease notification as required by law;
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____ Signature: _____

If not the Patient signing – Your name (please print): _____ Date: _____