Registration form for new patients under 15

PEARCEDALE MEDICAL CENTRE

Title ……Surname ……First name……

Child's 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 ……...

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

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

Child's Next of Kin Name…….. ……Child's Emergency Contact Name.. ……..

Relationship to Child ……..…Relationship to Child……..

Contact Number ……..Contact Number……..

Who is responsible for payment of accounts? (Name of parent/guardian responsible for account)

Name …… Contact number ……..……...

Relationship to Child …….. ……

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 ☐

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 form 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.

Artificial Intelligence (AI) Scribe Consent

Our practice uses AI medical scribes (such as Lyrebird Health or Heidi Health) to assist with clinical documentation. The tool listens to your consultation and drafts a clinical note.

- **Privacy:** No audio recordings are permanently retained. All data is processed and stored on secure, local servers. The drafted notes become a secure part of your medical record.
- **Your Choice:** You may decline the use of the AI scribe at any time, and this will not affect the quality or level of care you receive.

☐ **I consent** to the use of AI tools for clinical documentation during my consultations.
☐ **I do not consent** to the use of AI tools.

Patient (please print):_____ Signature:_____

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