PATIENT REGISTRATION

First name: _____ Surname:_____

Preferred name:_____

Date of birth: _____ Country of birth: _____

Medicare number: _____Expiry date: _____

Private Health fund: _____ Membership number: _____

Aboriginal: ☐ or Torres Strait Islander: ☐ Both: ☐ Neither: ☐

Address: _____

Suburb: _____State: _____Postcode: _____

Home phone number:_____Mobile:_____Work number:_____

Occupation: _____

Emergency contact

Name: _____ Relationship to you:_____

Address: _____

Suburb: _____State: _____Postcode: _____

Home phone number:_____Mobile:_____Work number:_____

Parent / guardian /Next of kin

Name: _____ Relationship to patient:_____

Address: _____

Suburb: _____State: _____Postcode: _____

Home phone number:_____Mobile:_____Work number:_____

Occupation: _____

Use of email/sms

I understand that I can choose to have information for routine reminders by email/sms. This service is restricted to administrative purposes only to protect the privacy and confidentiality of patients as total security cannot be guaranteed. In providing an email address /mobile phone number, I acknowledge the risks and consent for my email/mobile phone number to be used for this purpose.

EMAIL ADDRESS: _____

CONSENT TO COLLECTION OF PERSONAL AND HEALTHCARE INFORMATION

As a patient of this 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 of your health information at all times. 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 your personal information, and its use for the following reasons:

- Administrative purposes
- Billing purposes (including compliance with Medicare and the Dept. of Health and Ageing requirements)
- Disclosure to others involved in your healthcare. This may include allied health professionals, other specialists and health practitioners outside of this practice. This may occur through referral to others or for medical tests and in the reports or results returned to us following referral.
- Disclosure to other doctors in the practice for the purposes of patient care and teaching.
- For research and quality improvement purposes to improve individual and community health care and practice management (this will only be information that does not identify individual patients)
- To comply with regulatory or legislative requirements such as notifiable diseases or where the health and well-being of you or other/s is at significant risk of harm.
- For reminders and recalls which may be sent to you via sms, email or letter regarding your healthcare and management.

You can decline to have your health information used in all or some of the ways outlined above, but it may influence the practice's ability to manage your healthcare to provide the best outcome.

PLEASE READ EACH STATEMENT CAREFULLY AND TICK THE BOX IF YOU AGREE	
I have read the information above and understand the reasons why the 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 or if I provide information but want to put limitations on access or disclosure, I will discuss these with the practice beforehand.	
I am aware of my rights to access information collected about me, except in circumstances where access may be legitimately withheld. I understand I will receive and explanation of why the information is being withheld in these circumstances.	
I understand that if my information is to be used for any other purposes other than those set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purposes set out on this form.	
I understand that depending on the age of my child, and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	
I understand that if I request access to information held about me, I may be charged a fee to cover the administrative costs in providing access.	
OR	
I am unsure and would like to discuss further with someone from the medical practice before signing	

Patient name: _____

Patient / Parent / Guardian signature: _____ Date: _____

Parent / guardian name: _____