	REC043 - Patient Registration Form	

Personal Details

Title: (please circle)	Mr / Mrs / Ms / Miss / Mast / Other:	
Surname:	First Name:	
Middle Name:	Preferred Name:	
Date of Birth:	Birth Sex: Female / Male / Other / Unknown	
Gender: Female / Male / Non-binary / Transgender / Other	Pronouns: She/her/hers He/him/his They/them/theirs	
Do you identify as Aboriginal or Torres Strait Islander? Yes / No	If yes, please circle: Aboriginal / Torres Strait Islander / Both	
Country of Birth:		
Residential Address:	Suburb:	Postcode:
Postal Address: As above ☐	Suburb:	Postcode:
Home Phone:	Work Phone:	
Mobile Phone:	Occupation:	
Email:		

Medical Information

Medicare Card No: __ __ __ __ __ __ __ __ __ __ __ Ref No: __ Expiry: __ __ / __ __ __ __

Pension/Health Care Card No: __ __ __ __ __ __ __ __ __ __ Expiry: __ __ / __ __ / __ __ __ __

Card Type: (please circle) Pension / Health Care

DVA Card No: __ __ __ __ __ __ __ __ __ Expiry: __ __ / __ __ __ __

DVA Card Type: (please circle) Gold / White / Orange

Emergency Contact Information

NEXT OF KIN	
First Name:	Surname:
Address:	
Contact Number:	Relationship:
EMERGENCY CONTACT As above ☐	
First Name:	Surname:
Address:	
Contact Number:	Relationship:

Health History

	YES	**NO**	**Date of Diagnosis**	**Details**
Do you have any allergies or are you sensitive to drugs or dressings?				
Do you have or had a history of operations?				
Asthma				
Diabetes				
Hypertension				
Chronic Illness				
Other				

Family History

Father	Mother
Brothers & Sisters	Grandparents

Social History

	YES	**NO**	**How many per day**	**How many per week**
Do you smoke?				
Do you drink alcohol?				

How did you find out about us?

- □ Search Engine
- □ Facebook
- □ Website
- □ Hotdoc
- □ Word of mouth
- □ Other ______________________________

Communication

I consent to receive SMS appointment reminders, clinical reminder messages and emails.

Yes / No

Privacy and Terms

At this practice, we collect personal information from our patients for the primary purpose of providing quality health care services. 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.

To ensure the security of personal information held in this practice, all records are stored on computer, are password protected 0and are only accessible by authorised staff (all of whom have signed confidentiality agreements) within the practice. This practice will only use Medicare numbers collected from patients for the purpose of billing for medical services provided. The information you provide will only be for:-

- The primary purpose of providing quality health care services
- Administrative purposes for our medical practice
- Billing purposes, including compliance with Medical Australia requirements
- Disclosure to others involved in your health care, including treating doctors, specialists and medical technicians outside of this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us
- Disclosure to other doctors within this practice, locum, for the purpose of patient care
- Disclosure for research and quality assurance activities (using only de-identified data) to improve individual and community health care and practice management.
- Disclosure to State and Commonwealth Reminder Systems Pap Smear Register, Immunisation Register for preventative health care and My Health Record updates.

In other situations we would not disclose your personal information without obtaining your consent.

We will endeavour to ensure that all personal information collected is accurate, complete and correct.

Patients who wish to access their personal health information are welcome to discuss these matters with their treating doctors. Should access be denied, a reason for this denial will be provided to you. Should you require a copy of your personal information an administration fee may be incurred.

I have read and understood the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information and can request a copy of this privacy policy if I choose.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I therefore consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice of.

Patient/Guardian Signature: ____________________________________ Date : / /