New Patient Registration Form

burgundy street FAMILY MEDICAL

Title	□ Mr □ Mrs □ Ms □ Mast	□ Miss □ Dr □ Other (Specify)
Family name		
Given name/s		**Preferred name:**
Date of birth (dd/mm/yy)		**Sex at Birth** □ Female □ Male
Gender identity	□ Female □ Male □ Non-binary	□ Gender diverse □ Transgender □ Other (please elaborate):
Pronouns	□ She/her/hers □ He/him/his	□ They/them/theirs
Ethnicity (or country of birth)	□ Aboriginal □ Torres Strait Islander	□ Aboriginal & Torres Strait Islander □ Australian □ Other (Specify):
Street address		
Suburb		**Postcode**
Postal address (if different)		
Contact details	**Home:** **Mobile phone:**	**Work:**
Email address		**Occupation**
Consent to SMS	□ Yes □ No	Used to notify of results, appointments etc.
Allergies	□ Yes (Specify)	(if so, please advise your doctor)
Social History: Tobacco	□ No □ Yes	Number _____day/ _____week or □ Ceased smoking
Alcohol	□ No □ Yes.	Number per_____day/_____week/_____month
Drug Use	□ No. □ Yes. Type ____frequency	
Measurements	Height (cm)____	Weight (kg)_____
Consent to upload to My Health Record	□ Yes □ No	
Medicare number		Ref ------ Expiry / /
Health Care Card number		Ref ------ Expiry / /
DVA details		DVA details
Payer of account (under 16 years to be linked to parent on Medicare card)	□ Self □ Parent	□ Guardian □ Other
Parent/Guardian's full name and D.O.B (if patient is under 16 years)	Family name: Given name:	Date of birth / / Medicare (if different from above)
Next of Kin / Emergency Contact	Title: Given name:	Family name Date of birth / /
Address of Next of Kin/Emergency Contact	□ As above OR:	**Relationship to the Patient:**
Phone contact of Next of Kin/Emergency	Mobile:	Home: Work:

PLEASE TURN OVER AND SIGN THE CONSENT FORM

Patient Consent

Please read this consent form carefully prior to signing.

This general practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the Privacy Act 1988 and Australian Privacy Principles, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

" Administrative purposes in the operation of our general practice.

" Billing purposes, including compliance with Medicare requirements.

" Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.

" Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

" Accreditation and quality assurance activities to improve individual and community health care and practice management.

" For legal related disclosure as required by a court of law.

" For the purposes of research only where de-identified information is used.

" To allow medical students and staff to participate in medical training/teaching using only de-identified information.

" To comply with any legislative or regulatory requirements, e.g. notifiable diseases.

" 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.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) ----------

Signature: ---------- Date: ----------

If not patient signing - your name (please print)----------

Your relationship to patient (e.g. Mother, Father, guardian) ----------

PRACTICE USE ONLY:

Witnessed by: (staff signature)