



Patient Registration Form

PERSONAL DETAILS

Title : Mr / Mrs / Ms / Miss / Master Gender: Male / Female / Other

Family Name:.....

Given Name:..... Preferred Name:..... Date of Birth: / /

Address:..... Postcode

Postal Address: Postcode

Telephone: .Home: Work: Mobile

Occupation

Do you identify as being of Aboriginal/Torres Strait Islander descent? YES / NO : Aboriginal Torres Strait Islander Aboriginal/Torres Strait Islander

Cultural Heritage: e.g. Greek/Sri Lankan/Other Are you registered with "My Health Record" Yes No

Do you identify as belonging to a specific religious group?.....

Are you agreeable to us confirming appointments by SMS or contacting you on the above phone numbers? YES / NO

NEXT OF KIN / EMERGENCY CONTACT:

Next of Kin Name: Relationship to you:

Telephone: Home:..... Mobile:..... Work.....

Emergency Contact Name: Relationship to you:

Telephone: Home:..... Mobile:..... Work.....

BENEFIT DETAILS

MEDICARE NO: / / Ref No: Expiry Date: / /

PENSIONER HEALTH BENEFIT CARD: Expiry Date: / /

HEALTH CARE CARD: Expiry Date: / /

DEPARTMENT OF VETERANS' AFFAIRS:

PRIVACY STATEMENT – Privacy Act (Cwlth) 1988; Privacy Act Amendment 2001; Privacy Act Amendment 2012 outlining the Australian Privacy Principles (APP); Health Records Act (Vic) 2002

In keeping with the above Acts, we require your consent as follows:

Our Practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and contact numbers will be used for the purpose of addressing mail to you, utilising our recall system and SMS reminders.
2. We may disclose your health information to other health care professionals, or require it from them if, in our judgment, it is necessary in the context of your treatment. In that event, disclosure of your personal details will be minimised wherever possible.
3. We may also use parts of your de-identified health information for research purposes, in study groups or at seminars as this may provide a benefit to other patient.
4. Your medical history and any other material relevant to your treatment will be kept here. You may request copies of our records of your treatment, or seek an explanation from the doctor.
5. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.
6. All personal information is held securely, whether in electronic format, in protected information systems or in hard copy format in a secure environment.

You can be assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your consent. A copy of our Privacy Policy is available at reception.

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed : Date: / /