New Patient Registration Form

Personal Details

Title: Mr / Mrs / Ms / Miss /Mast / Dr	Mobile No
Surname	Home No
First name	Work No
Preferred name	Address
Gender Female ☐ Male ☐	
Date of birth	Postcode
Email	

Medicare, Pension, Health Care Card, or Veterans Affairs

Medicare card number	_ _ _ _ _ _ _ _ _ _ _ Ref No _	Exp /
Pension card number	Type: Pension ☐ HCC ☐	Exp /
DVA card number	Colour: Gold / White / Lilac / Orange	Exp /
Private Health Fund	Name: Number:	Exp /

Who can we contact in an emergency?

Next of kin	Name	Phone	Relationship
Emergency Contact ☐As above	Name	Phone	Relationship

Head of family (for patients under 18 years of age)

Given names: Family name:
Date of birth: / / Phone:

Medicare card number: _ _ _ _ _ _ _ _ _ _ Ref No _ Exp /

Knowing your cultural background can help us provide healthcare that meets your individual needs

Please circle one if applicable Aboriginal / Torres Strait Islander / both Aboriginal and Torres Strait Islander

If none of the above Cultural background: Country of birth:

Contact preferences

Would you like to be contacted via SMS mobile text message for recalls, appointment reminders, other test reminders and medical service notice? Y ☐ N ☐

In the event that our practice is unable to contact you in regards to urgent/abnormal results, do you give the practice the consent to contact your nominated emergency contact? Y ☐ N ☐

Consent Form

I fully acknowledge, understand and consent to the following:

I understand that I am free to withdraw my consent at any time by written notification.

I hereby give consent to Local Doctors to collect my health information for the purposes of assessment, diagnosis, treatment and care in respect to my health.

I understand that the practice may contact me by post, telephone or SMS for recalls and reminders.

As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls to be sent to the above address.

I understand that it may be necessary to disclose such information to a third party when it forms part of the treatment for an original condition. Disclosure may also be necessary if referral to another Medical Practitioner and Allied Health Practitioner is necessary.

By providing my email address, I acknowledge that I am aware of the privacy limitations placed on the practice as a result of the use of email. Email is not a secure form of communication, unless encrypted, and I understand that the practice cannot take responsibility for any privacy breach as a result of the use of email.

I acknowledge that Local Doctors undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All personnel accessing personal health information for this purpose have signed a written confidentiality agreement. I consent to my health record being reviewed as part of the quality improvement activities at this practice.

I understand that if I fail to give at least 24 hours' notice or fail to attend appointments, this may result in a cancellation fee of $35.

I understand that there will be a $20 administration fee if I request for my files to be transferred over to another practice.

*** If you have any concerns about the use of your personal health information, please speak with your GP or our Practice Manager. You may also visit our website and view our Practice Privacy Policy at any time if you would like more information.**

*** If you are under the age of 16, please have your parent or legal guardian print name and sign below**

Print name of Patient / Parent / Guardian (please circle):_____ _

Signature of Patient / Parent / Guardian (please circle): _____ _

Date: _____

Thank you for completing this form. Please advise us if your contact information or Medicare details change.