Hargreaves St
MEDICAL PRACTICE

New Patient Registration Form

Please present your Medicare card and applicable concession cards to reception

Contact Information

Family Name as per Medicare			
Given Name as per Medicare		Preferred Name	
Title		Gender	☐ Male ☐ Female ☐ Non-binary ☐ Other
Date of Birth			
Home address			
Home Phone		Mobile Phone	
Mobile Phone		Work Phone	
Email Address			

Healthcare Identifiers

Medicare Number											IRN	Exp / /
DVA File Number												Exp / /
Concession (pension/healthcare) card number												Exp / /

Cultural Identity

To assist with health initiatives – are you of Aboriginal and/or Torres Strait Islander descent? ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal & Torres Strait Islander ☐ No

Country of Birth		Ethnic Background	
Languages Spoken			

Do you require an interpreter service? ☐ Yes ☐ No

Patient Status

Do you have a MHR (My Health Record) ☐ Yes ☐ No ☐ Unsure

Next of Kin		Relationship to patient:	
Name		Home Phone	
Mobile Phone		Work Phone	

Emergency Contact		Relationship to patient:	
Name		Home Phone	
Mobile Phone		Work Phone	

This medical 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, treat and be pro-active in your health care needs. We may use the information you provide, in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclosure to other doctors, allied health workers and nurses who may work in the practice, including Locums and Accreditation Surveyors, for the purpose of patient care, teaching and accreditation.
- Disclosures for research and quality assurance activities to improve individual and community health care and practice management. This information will be de-identified.

By signing this document below, I agree to the following

- I have read 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.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.
- I consent or decline as indicated to receive an SMS message regarding future appointments
- I consent or decline as indicated to messages being left on telephone message service

Patient Name

Your name (if you are not the patient) Relationship to the patient

Signature Date