

## PATIENT REGISTRATION FORM

### PERSONAL DETAILS

Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ Given Name: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_ Gender:  Male  Female D.O.B. \_\_\_/\_\_\_/\_\_\_  
 Residential Address: \_\_\_\_\_  
 Postal Address: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Medicare Number: \_\_\_\_\_ Line Number: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_/\_\_\_  
 Private Health Insurance: \_\_\_\_\_ Number: \_\_\_\_\_  
 Health Care  Pension Card Number: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_/\_\_\_  
 DVA Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_  Gold,  White,  Lilac,  Orange  
 Do you have any allergies? Yes  No  *If yes, please comment* \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### CULTURAL BACKGROUND

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

Are you of Aboriginal or Torres Strait Islander origin?

Yes, Aboriginal  Yes, Torres Strait Islander  Yes, both Aboriginal and Torres Strait Islander

*If yes, Are you registered for 'Close the Gap'?* Yes  No

No  Other cultural background: \_\_\_\_\_ (e.g. Australian, Indian, Maori)

Is English your first language? Yes  No

*If no, do you require an interpreter?* Yes  No  Please specify language \_\_\_\_\_

### NEXT OF KIN DETAILS:

Full Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Home ph: ( ) \_\_\_\_\_ Mobile: \_\_\_\_\_

### EMERGENCY CONTACT DETAILS:

Full Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

Home ph:( ) \_\_\_\_\_ Mobile: \_\_\_\_\_

**For Children:** Head of Family: \_\_\_\_\_

### CONSENT

Our Practice uses a reminder system to help maintain your health. The Practice sends reminders by post, email or telephone for procedures such as vaccinations, cervical screens and other health reviews.

**Do you consent** to being contacted with reminders to help you maintain your health? Yes  No

How would you like to receive correspondence from us, via post or email? Email  Post

## HEALTHCARE PRIVACY NOTICE FOR PATIENTS

To enable ongoing care and continuity of total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information and medical records may be used and or disclosed to a third. This will allow you the opportunity to either consent or deny release of your details.

Your personal health information and medical records will only be used for the purpose for which they were collected ie: investigation reports, Medicare and health insurance details and from other sources like specialists correspondence or as otherwise permitted by law. We respect your right to determine how your personal health information is used and / or disclosed. We require your consent to collect personal information about you and to use the information as outlined below.

Please read this consent form carefully, and then sign where indicated below.

**I hereby consent to the use and disclosure of my personal health information and medical records, as required by Southern Cross General Practice for the following purposes:**

- Provide relevant information to other treating doctors, specialists or allied health professionals,
- For reminder letters which may be sent to you regarding your health care management,
- National or State registers (ie: immunisation data),
- State or Territory reminder systems (ie: cervical screening),
- Accounting, Medicare and Health Insurance Commission requirements (ie: billing),
- Quality assurance activities, such as; Accreditation,
- Disease notification as required by law (ie: infectious diseases),
- Disclosure to doctors, nurses and allied health professionals when consulting with you in this practice,
- Lawful disclosures as required by law (ie: subpoenaed documents), and
- For research purposes (anonymous)

**Any concerns about this form, then please feel free to discuss this with your doctor.**

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_  
*Guardian Name*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Patient Name*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*