NEW PATIENT REGISTRATION FORM

Title ____ First Name _____ Middle _____ Surname_____

Birth sex: FEMALE / MALE Gender Identity_____ Pronouns_____

Date of Birth ____ / ___ / _____ Aboriginal/ Torres Islander: Y N Country of Birth: _____

Home Address: _____

_____ Suburb: _____ Post Code: _____

Postal Address (if different to above)**: _____**

Preferred Contact Number: HOME / MOBLIE / WORK (please circle)

Phone Number: H _____ M _____ W _____

Email: _____

Medicare Card Number: _____ Ref Number: _____ Expiry: ___ / _____ NA

Concession (circle): SENIORS CARD, PENSION CARD/HEALTHCARE CARD /VETERANS AFFAIR CARD – GOLD/WHITE/ORANGE

CRN Number: _____ Expiry: ___ / ____ / _____

Health Insurance Fund (if any): _____ Number: _____

Next of Kin Contact:

Full Name: _____

Phone: _____

Relationship: _____

Emergency contact details:

Full Name: _____

Phone: _____

Relationship: _____

TAC OR WORK COVER CLAIMS SECTION ONLY

Tac or WorkCover: Y N Claim Number: _____

Insurance Company: _____ Address: _____

Employer: _____

You wish to consent for us to release information to third party: Y N
If consented to yes please provide with third party form

At our practice, we utilise Automed reminder software. This software provides appointment reminders, recalls & other preventative health reminders. If you do not wish to be contacted for these reminders, please discuss with Reception.

Patient Consent

This medical practice collects information from you for the primary purpose of providing quality healthcare. 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 proactive in your healthcare needs. This means we will use this information to provide in the following ways:

* Administrative purpose in running our medical practice

* Billing purpose, including compliance with Medicare and health insurance commission requirements. Please note we are not a bulk billing clinic unless under specific circumstances. Inquire with staff for further details. Unpaid accounts may be referred to a debt collector for collection

* Disclosure to other involved in your health care, including treating doctors and specialist 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 referral

* Disclosure to other doctors in the practice, locums and by registrars attached to this practice for the purpose of patient care and teaching. Please let us know if you don't want your records accessed for these purposes, and we will note your record accordingly.

* Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.

* I have read the information above and understand the reason why my information must be collected, I am also aware that this practice has a privacy policy and 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 healthcare and treatment given to me.

I am aware of my right to access the information collected about me, expect income 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.

I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure that I notify this practice.
Request for the release of medical history for Central Gippsland Family Practice to the patient will incur a fee of $25.00. The request for the medical history will not be processed until any outstanding accounts are paid in full.

Patients name: _____	
Patient Signature:	Date: ____ / ____ / _____