Patient Registration Form

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Please complete in BLACK BLOCK capitals or type.

Patient Details

Title (Please circle): Mr /Mrs /Miss /Other

First Name: Surname:

Date of Birth: / / Gender: ☐ Male ☐ Female ☐ Other ☐ Do not want to Specify

Medicare number: Expiry: / /

Pension number: Expiry: / /

DVA number: Expiry: / /

Facility details

Name:

Address:

Phone number: Fax Number:

Is the booking for ☐ New Patient **OR** ☐ Existing Patient ☐ Permanent **OR** ☐ Respite

Is the patient ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither

Main Language: Interpreter required: ☐ Yes ☐ No

Is the patient competent to make their own decisions: ☐ Yes ☐ No

If there is any other Medical treatment decision maker, please provide details below:

Name:

Phone Number: Mobile Number:

Relationship to patient: Email address:

☐ Medical treatment decision maker ☐ Enduring power of attorney ☐ Other

If other please provide details here:

Next of Kin (NOK) details

Name:

Phone Number: Mobile Number:

Relationship to patient: Email address:

Emergency Contact (if different from NOK)

Name:

Phone Number: Mobile Number:

Relationship to patient: Email address:

Advanced Care Directive and Wishes

Does the patient have an Advanced Care Directive: Y / N

If yes, then please provide:

Last review date:

Goals of Care:

Patient Registration Form

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Medical History (Eg: Dementia, AMI, Stroke, Diabetes, Hypertension, Osteoprosis, Thyroid dysfunction, major operations)

Allergies

Relevant family medical history

Medications

Health Information Collection and Use Consent

In order for us to appropriately analyse, diagnose, treat, and anticipate your health requirements as a patient of our medical practice, we need your personal information as well as a complete medical history. We want to keep your health information private and securely stored. A copy of our privacy policy, which details how your health information is gathered, used, and disclosed, is available upon request.

In order to gather personal information about you and use it in the manner listed below, we need your permission.:

- Administrative goals in the management of our medical office. billing objectives, as well as to fulfill Medicare and Health Insurance Commission regulations.
- Information sharing with other parties involved in your treatment, such as treating physicians and specialists outside of this practice. This might happen when patients are referred to other physicians, undergo medical testing, or have reports or results sent back to us after being referred.
- Disclosure made for the purpose of patient care and education to locums, other doctors in the practice, and other associated parties.
- To abide by any legal or administrative mandates, such as those regarding communicable illnesses.
- In order to enhance practice management and individual and community health care through research and quality assurance initiatives. Generally, anonymous information is used; but, if personally identifiable information is needed, you will be notified and given the option to “opt out” of any.

You have the option to refuse the use of your health information in any or all of the methods described above, but doing so may limit our capacity to provide you with the best possible treatment.

Kindly review the following statements and sign where appropriate. I’ve read the material above and am aware of the need for the collection of my personal data. I am aware that I am not required to divulge any information that is requested of me, but I also realise that not doing so could jeopardise the standard of the care and treatment I receive. I am aware of my rights to see the data that has been gathered on me, with the exception of certain situations in which access might be lawfully denied. I’ll get an explanation for these situations. I am aware that further consent will be sought if my information is to be used for any reason beyond those mentioned above. I agree that the practice may use my information for the purposes listed on this form, with the practice being informed of any restrictions on access or disclosure.

Name (or parent/guardian):

Date / /

Signature