Patient Registration Form

We need this information to provide the best quality care. This form complies with the RACGP standards for general practice. (5th edition). This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your GP.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, that allow us to contact you promptly about tests and results.

SECTION A: Personal Details

Title: (please circle) Master Mr Miss Mrs Ms Dr Sir Other _____

Surname: _____

Given Names: _____

Date of Birth: _____/_____/_____ **Gender:** (please specify) _____

Marital Status: (please circle) Single Married Defacto Separated Widowed

Medicare Card Number: _____ **Ref Number:** _____ **Expiry Date:** _____/_____

Pension Card Number: _____ **Ref Number:** _____ **Expiry Date:** _____/_____

Healthcare Card Number: _____ **Ref Number:** _____ **Expiry Date:** _____/_____

Veterans Affair Number: _____ **Type of Card:** _____ **Expiry Date:** _____/_____

Occupation: _____

Home Address: _____

Suburb: _____ **Post Code:** _____

Postal Address: _____

Suburb: _____ **Post Code:** _____

Mobile No: _____ **Home Number:** _____

Email: _____

NEXT OF KIN:

Name: _____

Address: _____

Suburb: _____ **Post Code:** _____

Mobile No: _____ **Relationship to you:** _____

Who can we contact in an emergency?

Name: _____

Address: _____

Suburb: _____ **Post Code:** _____

Mobile No: _____ **Relationship to you:** _____

Do you have an advance care directive for end-of-life care? (please circle) **Yes** **No**

SECTION B: Cultural Background

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

Are you Aboriginal or Torres Strait Islander Origin? (Please circle)

No **Yes, Aboriginal** **Yes, Torres Strait Islander** **Yes, Both Aboriginal and Torres Strait Islander**

Other Cultural Background: (please specify) _____

Country of Birth: _____ **Is English your first language?** (please circle) **Yes** **No**

If not, is an interpreter required? (please circle) **Yes** **No** **Specify Language:** _____

SECTION D: Consent

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

I consent to being contacted with reminders to help me maintain my health by post, email, telephone, or SMS (please circle)

YES **NO**

Our practice also sends information to the Australian Immunisation Register and Cervical Screening Register. These registers also send reminders, which can be helpful if you move.

I consent to being contacted with reminders to help me maintain my health from these organisations. (Please circle)

YES **NO**

Our practice can upload information that your request and grant permission for your My Health Record following discussion and consent form you.

I consent to information being uploaded to My Health Record following discussion with me. (Please circle)

YES **NO**

Information collected by your doctor will be used to provide you with quality patient care. Your personal health information will be kept confidential and will not be disclosed, unless required by law, to any third party without your consent wither verbally or in writing. I consent to the collection of medical information for the purpose of providing me with quality patient care. I am aware of my right to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given explanation in these circumstances.

_____ _____

Signature of Patient or Guardian **Date**

Office Use Only

Entered By: _____ Date: _____

Scanned & Matched to patient File Y N Nurse Tray Y N