

New Patient Registration Form

Please complete and return to reception

Section A — Personal Contact Details

(Name as it appears	s on your Medicare Card)			
Do you plan to be a r	regular patient?			
Title	Mr Mrs Master Miss Dr	Country of birth		
Family/Surname		Are you Aboriginal or Torres Straight Islander? Y N		
Given Name				
Preferred Name				
eHealth Record	Y N			
Date of Birth	D M Y	Age		
Gender	Male Female	Occupation		
Interpreter (Languag	ge if required)			
Home address				
		Postcode		
Postal address				
		Postcode		
Home Phone		Mobile Phone		
Work Phone		Email		
Do you consent to S	MS/Email Communication Y N			
Section B — (Government Identifiers			
Medicare Card Numb	ber	Patient Number on card Expiry M Y		
Centrelink HCC/Pens	sion Number	Expiry M Y		
DVA Number		Gold/White/Lilac/Orange		
Conditions		Expiry M Y		
Section C — E	Emergency Contact			
Family/Surname		Given Name		
Relationship to patie	nt	Gender Male Female		
Home phone		Mobile phone		
Email				



Section D —	Account Paye	r			
Self/Other (Name)			Date of Birth D M Y		
Address			Home phone		
			Mobile phone		
Email					
Section E — I	Medical Histor	У			
Any Known Allergies Y N			If so, to what?		
Describe reaction?					
Please list current m	nedications				
Please note past/cu	urrent medical cond	itions			
Heart disorders	Y N	Asthma	Y N	Blood pressure	Y N
Blood disorders	Y N	Kidney Disease	Y N	Epilepsy	Y N
Arthritis	Y N	Migraine	Y N	High Cholesterol	Y N
Depression	Y N	Diabetes	Y N	Cancer (inc. skin)	Y N
Family History (e.g.	. Diabetes, blood pre	essure, cancer, depression,	cause of death)		
Mother			Father		
Siblings			Children		
Alcohol/Tobacco			Do you currently smoke Y N		
Number of cigarettes per day?			Have you ever smoked? Y N		
For how long – how	many – If ceased, wh	en (year)			
Section F — I	mportant Info	rmation/Privacy Po	licy		
Transfer of Health Information If you have consulted with another GP at another practice, the			Student participation Our medical clinic is an accredited teaching practice for undergraduates and postgraduates. Students will		

Health Information held by that GP may assist us with your future healthcare needs. If you wish to have a copy/summary of your health records transferred to this clinic, please ask our reception for information on how this can take place.

Reminders & Recalls

Our medical clinic automatically provides our patients with preventative care and early detection reminders and recalls via mail. If you do NOT wish to receive reminders, please advise our reception staff

Privacy Policy

We are committed to maintaining the confidentiality of your personal information in keeping with the Privacy Act, 2001. It is clinic policy to maintain the security of personal health information at all times and to ensure this information is only available to authorised practitioners. Information may be disclosed to other organisations where required by law or if necessary contact details may be disclosed for debt recovery purposes. Our privacy policy is available at our reception and on our website.

observe consultations from time to time. If you do NOT wish for them to be present during your consultation, please advise our reception staff.

Payment details: Please note we are NOT a bulk billing clinic and out of pocket fees apply

- Payment in full is requested at the time of consultation. Cash, EFTPOS, Visa, MasterCard and AMEX are all accepted
- A \$10.00 accounting fee will be charged if your account is not paid in full on the day of the consultation
- Accounts referred to a debt collection agency or solicitor will incur a debt collection fee.
- A \$20 non-attendance fee will be charged for consultions not cancelled within 24 hours.
- By signing this form, you accept the terms and conditions above (to be signed by the person liable for the accounts).

Signed	Date D M Y