**Patient Registration Form**

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| **PERSONAL DETAILS** | | | | | |
| Title:  Click here to enter text. | Surname:  Click here to enter text. | | | Given Name:  Click here to enter text. | Prev. Surname:  Click here to enter text. |
| Address:  Click here to enter text. | | | | Suburb:  Click here to enter text. | Postcode:  Click here to enter text. |
| Home Phone:  Click here to enter text. | | Work Phone:  Click here to enter text. | | Mobile:  Click here to enter text. | Country of Birth: Click here to enter text. |
| Sex: (please tick)  M  F  X | | Date of birth:  Click here to enter text. | | Email:  Click here to enter text. | Occupation:  Click here to enter text. |
| Medicare Number: Click here to enter text. | | Ref no: Click here to enter text. | Expiry:  Click here to enter text. | Pension/Health Care Card:  Click here to enter text. | Expiry:  Click here to enter text. |
| **PRIVATE HEALTH FUND/VETERANS AFFAIRS** | | | | | |
| Private Health Fund:  Click here to enter text. | | Member number:  Click here to enter text. | | Vet Affairs Number:  Click here to enter text. | Expiry:  Click here to enter text. |
| **GENERAL PRACTITIONER** | | | | | |
| Name:  Click here to enter text. | | Clinic:  Click here to enter text. | | Suburb:  Click here to enter text. | Phone:  Click here to enter text. |
| **REFERRING DOCTOR (if not GP)** | | | | | |
| Name:  Click here to enter text. | | Suburb:  Click here to enter text. | | Phone Number:  Click here to enter text. |  |
| **NEXT OF KIN** | | | | | |
| Name:  Click here to enter text. | | | | Phone Number:  Click here to enter text. | |

***Consent to Collect Patient Information***

*This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways: administrative purposes in running our medical practice; research purposes; billing purposes, including compliance with Medicare and Health Insurance Commission requirements; disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.*

*I understand the reasons why my information must be collected. I consent to the practice collecting information relevant to my condition from other medical practitioners such as GPs, specialists, health care providers, pathologists, radiologists, hospitals or day surgeries. I understand that I am not obliged to provide any information requested of me, but that not doing so might compromise the quality of the health care and treatment given to me. I am aware that I may apply to access my health records, except in some circumstances where access may legitimately be withheld. I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.*

Patient’s signature: Click here to enter text. Date: Click here to enter text.