HEALTH ON CENTRAL

Patient Registration Form

Title: _____ First Name: _____ Surname: _____

DOB: _____ Gender: _____ Religion: _____

Do you identify as: Aboriginal Torres Strait Is Both N/A

Sex at Birth: _____ Gender Identity: _____ Your Pronouns: _____

Country of Birth: _____ Language Spoken: _____

Occupation: _____ Employer: _____

Home Address: _____ Suburb: _____ Postcode: _____

Postal Address (if different): _____

Email: _____

Phone (H): _____ (M): _____

Medicare Number: _____ REF: _____ EXP: _____

Pension Card Number: _____ Expiry Date: _____

HCC Number: _____ Expiry Date: _____

DVA Number: _____ circle: Gold White Expiry Date: _____

Private Health: YES NO Health Fund: _____

Membership Number: _____

Next of Kin: _____ Phone: _____

Relationship: _____

Emergency Contact (other than NOK): _____ Phone: _____

Relationship: _____

Do you consent to receiving reminders via SMS (circle): YES NO

Would you like your next of kin to have access to your medical records? (circle) YES NO

HOW DID YOU HEAR ABOUT US? _____

Medical History	Yes	No	Details
Relevant Medical History			
Allergies			To What? What happens?
Current Medications			
Immunisations Complete			
Alcohol Intake			How Often: Amount:
Smoking History			☐ Never ☐ Ex-Smoker ☐QTY/day
PLEASE INDICATE IF YOU OR YOUR FAMILY MEMBERS HAVE OR HAD THE FOLLOWING:-			
Cancer			Who:
Heart Disease			Who:
High Blood Pressure			Who:
Diabetes			Who:
Asthma			Who:
Other Conditions			

Privacy

I consent to my Doctor collecting my personal health information for appropriate ongoing care. This information may be released to preferred health care professionals if required.

Signed _____ Date: _____

26 Central Drive, Andergrove, Qld, 4740
Ph: (07) 4955 0555 Fax: (07) 4955 0993
admin@healthoncentral.com.au
www.healthoncentral.com.au

Health Information Collection,
Use and Disclosure: Patient Consent Form

Dear Patient,
Health on Central collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed; we will record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods, and may include, but not limited to: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists 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 referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy, and disclosure of your patient information.

Consent

I, _____ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

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I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____Date: _____

If not patient signing - your name (please print) _____

Your relationship to patient (e.g. Mother, Father, guardian)_____

PRACTICE USE ONLY:

Witnessed by: (staff signature)_____

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