PATIENT REGISTRATION FORM

Personal Details

Surname	
First name	
Preferred name	
Title (Mr/Mrs/etc.)	
Date of birth (dd/mm/yyyy)	

Home Address

Address line 1	
Address line 2	
Suburb	
Postcode	

Postal Address (leave blank if same as Home Address)

Address line 1	
Address line 2	
Suburb	
Postcode	

Contact Details

Mobile number			
Home number			
Work number			
Email address			
Do you consent to your correspondence being sent electronically?		Yes	No

Next of Kin

Surname	
First name	
Relationship	
Contact number	

Emergency Contact (leave blank if same as Next of Kin)

Surname	
First name	
Relationship	
Contact number	

Medicare Details

MC card number	
Reference number	
Expiry date	

DVA Details (if applicable)

DVA card number	
Type (Gold/White)	
Expiry date	

Concession Card Details (if applicable)

Centrelink card number	
Concession type	
Expiry date	

Cultural Identity I (for funding purposes – leave blank if not applicable) – tick appropriate box

Do you identify as an Aboriginal or Torres Strait Islander?	
Aboriginal	
Torres Strait Islander	
Prefer not to specify	

Cultural Identity II (for translation and interpretation purposes – optional)

Do you identify as someone from a culturally and/or linguistically diverse background?	
If yes, please elaborate	
If yes, tick here if you require an interpreter service	
Preferred spoken language:	

How Did You Find Us (tick appropriate boxes)

Following GP from previous clinic	
Street signage	
Google search	
Social media (e.g., Facebook, Instagram)	
Recommended by family member	
Recommended by friend	
Other – specify:	

Allergy Information

I have allergies	Yes	No
Details:		

Smoking (tick appropriate box)

I currently smoke	
I have never smoked	
I am a former smoker	

Alcohol (tick appropriate box)

I do not drink	
I rarely drink	
I drink daily	
I drink weekly	
I drink monthly	

Reviewed by: Dr Ern Chang/Practice Principal /30/09/2020
Next Review Date: 30/09/2023

PATIENT REGISTRATION FORM

CLINIC PRIVACY STATEMENT

Please read this carefully. You may also view this statement at our website.

Family Doctors Highton ("FDH") 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 – Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and 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. 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. Information may include test results, consultation records, 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 FDH;
- Billing purposes, including compliance with Medicare requirements;
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by text messaging or via HotDoc;
- 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; and
- For use when seeking treatment by other doctors at FDH.

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.

PRIVACY CONSENT

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

1. I have read Family Doctors Highton's *Clinic Privacy Statement* 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.

2. I give permission for my personal information to be collected, used and disclosed as described above, including contact via text messaging to my mobile phone number. I understand 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		If signing on behalf of, state your name	
Signature		Your relationship to the patient	
Date		Date	

Official use only

Received by:	
Via email:	