Ashford Avenue
Family Practice

Patient Registration Form

Patient Details				
Title	◯ Mr ◯ Mrs ◯Ms ◯ Master ◯ Miss ◯ Other:			
Surname				
First Name				
Middle Name				
Date of Birth				
Address				
Postal Address (if different)				
Home Phone				
Work Phone				
Mobile Phone				
Occupation				
Medicare Number	Ref No:		Expiry Date	
Pension/Healthcare Card No (If Applicable)			Expiry Date	
DVA Number (If Applicable)			Expiry Date	

Next of Kin	Name:	Relationship:
	Telephone:	
	Address:	
Emergency Contact (if different to above)	Name:	Relationship
	Telephone:	
	Address:	

Cultural Background
Knowing your cultural background can help us provide healthcare that meets your needs.
Are you of Aboriginal or Torres Strait Islander Origin?

◯ Yes – Aboriginal ◯ Yes – Torres Strait Islander ◯ Yes – Aboriginal & Torres Strait Islander ◯ No

Cultural Background (e.g. Australian, Greek, Vietnamese)	
Country of Birth	

Transfer of Health Information
You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy of a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact information or Medicare details change.

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Patient Consent

This 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 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 and record your consent or restrictions to this consent.

The information we collect may be collected by a number of different methods and examples may include: 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 inside/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 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.

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.

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.

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 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) _____