BURPENGARY DOCTORS-PATIENT REGISTRATION FORM

◯ Dr ◯ Mr ◯ Mrs ◯ Miss ◯ Master

First Name: Middle: Surname:

DOB / /

Address:

Phone: Mobile: Work:

Email:

Medicare Number: ref: expiry:

Dept of Veterans Affairs: expiry: /

Health Care Card or Pension Card: expiry: /

Private Health Fund:

Martial Status: Occupation:

Do you identify as Aboriginal YES/NO Torres Strait Islander YES/NO ◯ Neither

If yes to the above, are you registered for Closing the Gap YES/NO

Languages spoken : Country of Birth:

Do you require an interpreter

Have you served in the Australian Defence Force(Permanent&/or Reserves) YES/NO

EMERGENCY CONTACT

Name: Relationship:

Home number: Mobile:

NEXT OF KIN

Name: Relationship:

Home number: Mobile:

Can we use your mobile phone number for SMS reminders for non-urgent preventative health YES/NO

ALLERGIES:

PAST HISTORY:

PAST HISTORY:

CURRENT MEDICATIONS:

Please turn over

Alcohol: per day days per week

Smoking: Never_____ Ex_____ Yes_____ per days
If you child is under the protection of custody agreement or is in shared care parental care, please indicate the party/parties who may request information regarding their health. Please provide a copy of court agreement

Patient Consent

Please read this consent form carefully prior to signing.

This general 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.

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 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 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.

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) _____