NEW PATIENT REGISTRATION FORM

(Please Circle Title) MR / MRS / MS / MISS / MST / DR / PROF OTHER (Please specify) _________	MARITAL STATUS (Please Circle or Specify ->)	Single, Married, DeFacto, Divorced, If Other (specify) ____________________
SURNAME (Please print clearly)	FIRST NAME	MIDDLE INITIAL/NAME
DATE OF BIRTH (i.e., DD/MM/YY)	KNOWN AS (If Different)	
RESIDENTIAL ADDRESS		
SUBURB	STATE	POSTCODE
POSTAL ADDRESS (Only required If different)		
PHONE (HOME)	MOBILE	
EMAIL ADDRESS:		
OCCUPATION		
(Please Circle) FEMALE MALE TRANSGENDER BINARY NON-BINARY WE		
MEDICARE CARD NUMBER and your (**10 numbers**)	**REF NO** (located beside your name)	EXPIRY DATE
HEALTH CARE CARD NO	CARD TYPE eg. Age, DISP	EXPIRY DATE
VET AFFAIRS CARD NUMBER	If GOLD state which conditions:	EXPIRY DATE
Category (Please Circle) - WHITE / GOLD / ORANGE		
ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER BOTH OR NON-INDIGENOUS		YES / NO / BOTH
COUNTRY OF BIRTH		
IMPORTANT - NEXT OF KIN - FULL NAME (Required)		Relationship to Patient
PHONE NUMBER (of your Next of Kin)		
EMERGENCY CONTACT - FULL NAME (Only required if different to Next of Kin)		Relationship to Patient
PHONE NUMBER (of your Emergency Contact)		Continued on reverse Please turn over ->

NEW PATIENT REGISTRATION FORM

Health Information Collection and Use Consent Form

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat, and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually, information that does not identify you is used but, should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements e.g., notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

Patient Name: ____

Patient Signature: ____

If a minor, Guardian: ____

Date: ____