Patrick Street Clinic - Patient Registration Form

ABN: 64 542 520 028

PLEASE NOTE – THIS PRACTICE IS NOT A BULK BILLING PRACTICE

Title (please circle) Dr/ Mr/ Mrs/ Ms/ Miss/ Master

First Name: _____ **Middle Name**:_____ **Surname**: _____

Preferred Name: _____ **Date of Birth:** _____/_____/_____

Birth Sex: ☐ **Male** ☐ **Female** ☐ **Unknown** **Gender Identity:** _____

Residential Address: _____

Suburb: _____ **Postcode**: _____

Postal Address (if different from above):

P O Box/Street: _____

Suburb: _____ **Postcode**: _____

Home No: _____ **Work No**. _____ **Mobile No**. _____

Email Address: _____

Preferred methods of contact? ☐ **Home** ☐ **Mobile Phone** ☐ **Mail** ☐**Email** ☐**SMS**

Occupation: _____

Ethnicity:

☐**Aboriginal** ☐**Torres Strait Islander** ☐ **Non Aboriginal & Torres Strait Islander** ☐ **Other** _____

Interpreter required: ☐**NO** ☐ **YES – language** _____

Our SMS does not include sensitive health information and is included in your practice health record.

Do you authorise the practice to send you SMS appointment confirmations? ☐**YES** ☐ **NO**

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks.
Do you wish to have any relevant reminders sent to you?

☐**Yes – SMS *OR*** ☐**Yes – via mail** ☐ **No**

Please present to Staff:

Medicare Card _____ **Ref No**_____ **Expiry**_____

DVA_____ **Expiry** _____**Health Care Card/ Pension Card** _____ **Expiry**____

Drivers License/Passport/ID card No. _____

(OFFICE USE: Name of staff member who sighted the above – _____ **)**

Next of Kin: **First Name**: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Emergency Contact: **First Name**: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Terms:

1. I accept that payment is required in full at the time of consultation
2. I accept that I am required to provide 2 hours' notice prior to cancelling my appointment
3. I will accept full liability for workers compensations claims which are rejected
4. I accept that if accounts remain unpaid no further medical service will be provided

Signed by:_____ Date: _____

Please turn over

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Your Health Information and Privacy

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- 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.

For a copy of our full privacy and email policies, please visit the website: www.patst.com.au or request a copy at reception.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____