WAVERLEY General Practice

Date:
Seeing Dr:

Registration Details

Please Circle: Mr / Mrs / Ms / Miss / Master/ Other **Date of Birth:**_____

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

Surname:_____ **Preferred Name:** _____

Home:_____ **Work:**_____ **Mobile:**_____

Email:_____

Address:_____

Suburb/City:_____Post Code:_____

Medicare Card No:_____

Ref No:_____

Exp Date:_____

3125 47247 5
1 John Smith
2 Jane Smith
Valid to 09/10

If you don't want to receive SMS reminders. Cross Box here ☐

This is how the clinic reminds you that you are due for things. i.e. ppointments/ results

Concession (please circle): Pension Veterans Healthcare card Commonwealth Seniors card None

Concession Card No:_____**Exp Date:** _____

Private Health Insurance (please circle): Basic Hospital Intermediate Top Hospital None

Country of Birth_____ **Language/s Spoken** **1.**_____

Ethnicity_____ **2.**_____

Aborginal/Torres Strait Islander? YES / NO **Interpreter Needed:** ☐ **Tick if yes**

Next of Kin/ who would we call incase of an Emergency??

Please circle: Mr / Mrs / Miss / Ms

First Name:_____Surname:_____

Address:_____ **Suburb:**_____

Phone Number:_____Relationship to the patient:_____

For Parents Registering Children Only - Medicare requires an Adults / Next of Kin Payer

Payer Medicare Reference no:_____**(order listed on card)** **Payer D.O.B:**_____

Payer Medicare no if different to above:_____ **Exp:**_____

PARENT/s NAMES/s:_____

How did you hear about the clinic?

Google ☐ **Yellow Pages** ☐ **Family are Patients** ☐ **Health Engine** ☐ **Saw sign out front** ☐

Personal recommendation/ by whom_____**Internet/ Which Site:**_____

Other:_____ **Mail out/flyer:**_____

Medical History
What is your occupation?_____ **Hobbies?**_____
Smoking (please circle) Never Smoker Ex Smoker
Have you suffered any major illnesses? Any operations?_____
Do you have any allergies?_____
Are you on any medication? What is it called?_____
Do you have any history of illness in the family?_____

PRIVACY STATEMENT – CONSENT FORM

This medical 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, treat and be proactive in your healthcare needs.

We require your consent to collect this personal information about you. The privacy policy is available on our website and can be viewed on request.

Please read the following information carefully, and sign where indicated below.

We will 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 requirement
- Deliver to you; appointment reminders, recall notices, health information, practice information and services , results of tests, by SMS, secure email, phone or letters unless you tell us otherwise.
- Disclosure to others involved in your health care, including treating doctors, ancillary practitioners and specialists outside this medical practice. This may occur through referral to other practitioners, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure to doctors, ancillary practitioners, locums and GP registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.

I have read the adjacent information and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the healthcare and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purposes other than those outlined at left, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes outlined at left, subject to any limitations on access or disclosure of which I notify this practice.

Name (or parent/guardian):

_____

D.O.B:_____/_____/_____

Signature :_____

Date:_____/_____/_____