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**Patient Registration & Information Form**

*We are committed to providing our patients with the best care.*

*To do this, it is essential that your health record is kept up to date and accurate.*

*ALL patients are asked to complete the following.*

**Family Name:**…………………………………………………………………………….. **Given Names:**…………………………………………………………………………………

**Preferred Name:**………………………………………………………………………… **Date of Birth:**…………………………………………….......................................

**Occupation:**……………………………………………………………………………….. **Title:** Mr Mrs Miss Ms Dr Other…………………………………………….

**Address:**……………………………………………………………………………………………………………………………... **Post Code:**……………………………….................

**Postal Address: (if different):**……………………………………………………………………………………………… **Post Code:**………………………………………………

**Mobile Number:**……………………………………………………...................... **Home Number:**………………………………………………………………………………

**Work Number:**……………………………………………………………………………

**Do you consent to SMS reminders: (circle)**  Appointments Yes No Clinical Reminders Yes No

**Do you consent to receive Electronic communication eg quarterly newsletter by email: (circle)** Yes No

**Email:**……………………………………………………………………………………………………………………………………………………………………………………………………..

**Birth Sex: (circle)** Male Female Other Unknown

**Gender Identity: (circle)** Male Female Non-binary Gender diverse Transgender

Different Identity ……………………………………………………………………………………………………………………………….

**Pronouns: (circle)** She/Her/Hers He/Him/His They/Them/Theirs

**Ethnicity:**…………………………………………………………………………… **Country of Birth:**……………………………………………………………………………

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| --- |
| Medicare Number:……………………………………………………………. Exp:……………./…………… Ref:……………………….Pension/Health Care Card Number:.………………………………………………………………………….. Exp:…………/…………..National ADF Family Health Program Number:………………………………………………………….. Ref:……………………….Do you have Private Health Insurance: (circle) Yes NoDVA Number:………………………………………………. Gold or White Exp:……………/………………..Conditions: for white card (provide letter from DVA as proof)……………..……………………………………………………….………………………………………………………………………………………………………………………………………………………………………. |

**Next of Kin: Name:**………………………………………………………………………………………………………………………………………………………………………………

**Relationship:**………………………………………………………………………….. **Phone Number:**…………………………………………………………………………..

**Alternative/Emergency Contact:** Preferto*be different to Next of Kin.*  **Name:**…………………………………………………………………………………………

**Relationship:**…………………………………………………………………………. **Phone Number:**…………………………………………………………………………..

**Head of Family (only required for children under 17 years of age): Name:**………………………………………………………………………………………..

**Do you identify yourself as: (circle)** Aboriginal Torres Strait Islander Both Neither

**How did you hear about us?(circle)**

Word of Mouth Radio TSAJ website Google Search TSAJ Facebook page Professional referral Other Social Media

***Failure to attend an appointment or cancel without 2 hours notice may result in a Did not attend or Cancellation fee.***

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**Health Information Collection and Use Consent Form**

**The Surgery at Jerra**

**1/37 Jerrabomberra Parkway**

**Jerrabomberra NSW 2619**

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, but not limited to, 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 through 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, or 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 this is information that does not identify you 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 eg notifiable diseases.
* For reminder letters which may be sent to you regarding your health care and management.

Please read this consent form carefully and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you. (please initial in each box)

|  |  |
| --- | --- |
| I have read the information above and understand the reasons why my information must be collected. |  |
| I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. |  |
| I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. |  |
| I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. |  |
| I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. |  |

**Patient’s name:** ……………………………………………………………… **Date:** ………………………………………..

**Patient’s signature:** ………………………………………………………… **Signed as Guardian for child:**………………………………

 *Practice Internal Use: Received by \_\_\_\_\_\_\_\_\_\_ Entered by\_\_\_\_\_\_\_\_\_*