WITHCOTT
MEDICAL CENTRE

PATIENT REGISTRATION FORM

Please present Medicare Card and any applicable concession card to reception

4 Jones Road Withcott 4352
Phone (07) 4630 3677 Fax (07) 4630 3499

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.

Contact & personal information

Family Name: _____ Title: Mr / Mrs / Ms / Miss / Mast/ Other_____

Given Name: _____ Preferred Name: _____

Date of Birth: _____/_____/_____ Gender: Male / Female / Other_____

Preferred Pronouns: She / He/ They

Residential address: _____

suburb: _____ post code: _____

Postal address: _____

Telephone: Mobile_____ Home_____ Work_____

Email: _____

Cultural identity

To assist with health initiatives – are you of Aboriginal and/or Torres Strait Islander descent? ☐ No

☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal & Torres Strait Islander

Nationality (if not Australian): _____

Healthcare identifiers

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Individual Ref No (the number beside your name):_____ Expiry Date: _____/_____

DVA Number: _____ Card Type: Gold / Orange / White - Please specify conditions:

_____

_____

_____

Pension Card No.: _____ Expiry: _____/_____/_____

Health Care Card No.: _____ Expiry: _____/_____/_____

C'wealth Seniors Health Card No.: _____ Expiry: _____/_____/_____

Next of Kin Relationship to patient

Contact Name: _____ Phone No.:_____

Address: _____Suburb:_____

I consent to results and personal information being released to the above person. ☐ Yes ☐ No

I understand that I can withdraw my consent by contacting Withcott Medical Centre either verbally or in writing.

Emergency Contact Relationship to patient

Contact Name: _____ Phone No.:_____

Address:_____Suburb:_____

I consent to results and personal information being released to the above person. ☐ Yes ☐ No

I understand that I can withdraw my consent by contacting Withcott Medical Centre either verbally or in writing.

Appointment reminders

Do you consent to receiving SMS reminders for your appointments? ☐ Yes ☐ No

Clinical reminders / messages

Our practice provides you with preventive care and early detection reminders, e.g immunisation, annual health checks, skin checks, pap smears etc.

Do you consent to being added to the reminder list and receiving SMS reminders? ☐ Yes ☐ No

Do you consent to receiving SMS clinical communications (recalls/ clinical messages) ? ☐ Yes ☐ No

Do you consent to receiving SMS Health awareness information ? ☐ Yes ☐ No

NB. Recalls and clinical messages will be sent to advise patients that they need to contact the practice to make a follow-up appointment or speak with a staff member. Specific clinical information will not be sent via SMS.

MyMedicare – Are you interested in registering for MyMedicare at our practice? ☐ Yes ☐ No

Consent

I consent for Doctors and Practice Staff to access and use my personal information so they can provide the best possible healthcare. Please refer to Withcott Medical Centre Privacy Policy for additional information.

Signature of Patient (Carer) or Guardian if Patient is a minor: _____

Date:_____/_____/_____

Personal Information Collection Notice

This personal information collection notice is a requirement of the *Information privacy Act 2009* and contains details about what personal information Withcott Medical Centre may collect, hold, use and disclose about you. You can find out more about how we deal with your privacy by requesting a copy of our privacy policy from reception.

Why we collect information

Our practice will need to collect your personal information to provide healthcare services to you. Our main purpose for collecting, using, holding and sharing your personal information is to manage your health. We also use it for directly related business activities, such as financial claims and payments, practice audits and accreditation, and business processes (eg staff training).

Disclosure of your information to other entities when necessary

The Practice sometimes shares your personal information:

- With other healthcare providers;
- With 3rd parties who work with our practice for business purposes, such as accreditation agencies, information technology providers – these 3rd parties are required to comply with APP's and this policy;
- To comply with any legislative or regulatory requirements e.g. notifiable diseases, court orders and mandatory reporting;
- When necessary to lessen or prevent a serious threat to a patient's life, health or safety or public health or safety, or it is impractical to obtain the patient's consent;
- To assist in locating a missing person;
- To establish, exercise or defend an equitable claim;
- For the purpose of confidential dispute resolution process; and
- During the course of providing medical services, through ehealth services.

Accessing your information

Our privacy policy details how you may access your personal information we hold, seek correction of such information and make a complaint against us if you feel we have breached any privacy legislation in dealing with your personal information.

Your consent

☐ I have read and understand the Collection Notice.

☐ 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 health care and treatment given to me.

Patient Name: _____

Signature: _____

Date: _____/_____/_____