

## New Patient Registration Form

It is our great pleasure to welcome you to the Jindalee Care Medical Practice. We are dedicated to the highest standard of professional care for all our patients. Our aim is to partner you in maintaining your long-term health and well being. This is our commitment to you.

**PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS**

FIRST NAME	SURNAME	MISS MS MRS	MSTR MR	DR
KNOWN AS				
DATE OF BIRTH (i.e. DD/MM/YY)				MALE / FEMALE
MEDICARE CARD NUMBER	Ref No	Expiry Date		
CONCESSION CARD	Ref No	Expiry Date		
VET AFFAIRS CARD NUMBER		Expiry Date		
RESIDENTIAL ADDRESS				
SUBURB		STATE	POSTCODE	
HOME PHONE	WORK PHONE	MOBILE		
EMAIL ADDRESS				
PLEASE CIRCLE	Aboriginal	Torres Strait Islander	Both	Non Indigenous
MARITAL STATUS				
OCCUPATION				
COUNTRY OF BIRTH				
ETHNICITY (e.g. Caucasian, African, Asian etc.)				

DETAILS OF YOUR **NEXT OF KIN**

DETAILS OF YOUR **EMERGENCY CONTACT**

<b>NAME</b> Mr/Mrs/Miss/Ms	<b>NAME</b> Mr/Mrs/Miss/Ms
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
HOME PHONE	HOME PHONE
MOBILE	MOBILE

Our practice uses a reminder system to help maintain your health. We provide our patients with preventative care and early case detection reminders e.g. Blood test results, immunisation, annual health checks, skin checks, cervical screening via an SMS system. We also utilise an SMS system for appointment reminders.

I consent to being contacted via SMS with reminders to help me maintain my health. Yes  No

Please be aware that you are responsible for following up any results you may have.

Results are NOT given over the phone. You will need to make an appointment with your doctor to receive your results.

Patients Signature or Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## NEW PATIENT REGISTRATION FORM - PATIENT CONSENT

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 pro-active in your health care needs.

**We may 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 health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports returned to us following the referrals.
- Disclosure to other doctors, allied health workers and nurses who may work in the practice, including Locums and Accreditation Surveyors, for the purpose of patient care, teaching and accreditation

**By signing this document below, I agree to the following:**

- I have read the information above 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 health care 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 other purpose other than set out above, my further consent will be obtained.
- By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access or disclosure that I notify the practice of.

**I provide my consent for Jindalee Care Medical Practice to collect, use and disclose my personal information as outline above. I provide consent for referrals and results to be sent to a medial specialist or doctor by facsimile.**

**I authorise Jindalee Care Medical Practice to process my consultation fee via electronic billing with Medicare Australia, as we are a paperless practice.**

Patient / Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Guardian Relationship: \_\_\_\_\_

