Patient Registration Form

Please present your Medicare card and applicable concession cards to reception

Contact Information					
Family Name (as per Medicare)					
Given Name (as per Medicare)			Preferred Name		
Title		Gender	Female ☐ Male ☐ Non-Binary ☐ Trans gender ☐ Other:		
Ethnicity (e.g. Australian, Indonesian, Korean)					
Date of birth					
Home Address					
Postal Address					
☐ Same as above					
Home Phone					
Mobile phone		Consent to SMS appointment reminders	Yes ☐ No ☐		
Work phone					
Email		Consent to email communication Yes ☐ No ☐			

Cultural Identity – do you identify as being:

Aboriginal Yes ☐ No ☐ Torres Strait Islander Yes ☐ No ☐ Both Aboriginal and Torres Strait Islander Yes ☐ No ☐

Healthcare Identitfiers				
Medicare Number		Ref no:	Expiry	
DVA File Number			Expiry	
Concession (pension/healthcare) card number			Expiry	
Do you have Private Health cover Yes ☐ No ☐	If yes, name of Insurer:			
Next of Kin		**Relationship to Patient**		
Contact Number/s				
Emergency Contact (if different from NOK)		**Relationship to Patient**		
Contact Number/s				

Communication

I understand that Your Health Hub may need to contact me in the **method most appropriate**. My **preferred** methods of contact are *(tick all if applicable)*: Phone ☐ Letter ☐ SMS ☐

Reminders: I consent to the following **4 types of reminders** (*tick all if applicable*):

Appointment Reminders ☐ **Clinical Reminders** ☐ **Clinical Communications** ☐ **Health Awareness** ☐

(e.g. Immunisations) (e.g. Results) (e.g. New Services)

Do you give consent for our **clinical** staff to access your **My Health Record?** Yes ☐ No ☐

By signing below, I consent to communication as indicated, I also acknowledge that Your Health Hub is a private billing practice and I accept responsibility for payment of all associated fees.

Signed: Date:

YOUR HEALTH HUB
Medical & Allied Health Centre

Privacy and Policy Consent Form – Australian Privacy Principles.
Please read this consent form carefully prior to signing

This general 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 and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent. Your personal 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 information is used or disclosed.

We may collect information using various methods, such as: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).
Your personal information may be collected, used or disclosed by the practice for the following purposes:

- Administrative purposes in running our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare.
- Disclosure to others involved in your health care, 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 the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- 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.
By signing this form, you (as a patient/parent/guardian) are consenting to the collection, use and disclosure of your personal information as described above. Please sign below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information:

▪ I have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed.

▪ I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

▪ I give my permission for my personal information to be collected, used and disclosed as described above including contact via SMS to my mobile phone number and/or email to the address I've provided.

▪ I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

▪ I believe the information that I have provided on this form to be true and correct.

Patient name (Please Print): _____

Responsible Guardian Name: _____

Your relationship to patient (e.g. Mother, Father, guardian): _____

Signature: Date: