NEW PATIENT REGISTRATION FORM

fountainstreet GENERAL PRACTICE

Title ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Master ☐ Dr. ☐ Prof	
Surname:	**Patients Medicare Number:**
First Name: **Preferred Name:**	**Ref /Line No:**
Middle Name:	**Expiry:**
Date of Birth / / **Sex** ☐ M ☐ F	

Street Address:	
Suburb and Post Code:	
Home Phone:	
Work Phone:	
Mobile Phone :	
Email :	**Occupation:**

☐ **DVA Gold** ☐ **DVA White** (Please tick which)	**No**:	**Expiry:**
Pension Number:	**No**:	**Expiry:**
Health Care Card Number:	**No:**	**Expiry:**

Next of Kin : (Name and Telephone number)	**Relationship**		
Emergency Contact: (Name and Telephone number of the person we can contact if needed)	**Relationship**		
Head of Family (if patient is a child <16) *This is a Medicare requirement* **Name:**	**Medicare Number:**	**Expiry:**	**D.O.B.**

Patient Background

Do you identify as someone from a culturally and/or linguistic diverse background?
☐ No ☐ Yes. Please elaborate:
To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
☐ No ☐ Yes - Torres Strait Islander ☐ Yes – Aboriginal ☐ Yes – Aboriginal & Torres Strait Islander

Patient Consent for use of Personal Health Information

a) Within the Practice

I, _____ , give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want my medical or personal information disclosed to other doctors or staff of this practice I need to inform my usual doctor of this issue.

b) Outside the Practice

Furthermore, I agree to allow my doctor to communicate relevant medical details to Specialist Doctors, Hospital Medical Staff, Pathology labs and other Health Care Providers e.g. Physiotherapists, Podiatrists etc involved in my medical care.
This practice from time to time participates in Medical Research projects with outside organisations. We stress that all information shared is ***depersonalised*** (i.e. names of patients are not given)
If you DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box ☐

c) For Dependant

As Parent/Guardian of _____ I authorise that their health information be also used in the above mentioned manner.

Your Signature -Patient/Parent/Guardian: _____ Date:

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?	
☐ Yes SMS this mobile phone_____	☐ No