DATE COMMENCED:

**STIRLING CENTRAL HEALTH CLINIC**

# NEW PATIENT REGISTRATION

**Surname**

**Given Name(s)**

**Preferred name**

**Date of Birth** / /

**Sex**

**Ethnicity**

- ☐ **Aboriginal**
- ☐ **Torres Strait Islander**
- ☐ **Both**

**Address**

**Post code**

**Home no.** ( )

**Work no.** ( )

**Mobile no.**

**Email**

**Allergies** (indicate if nil known)

| *Substance* | *Response* |
|---|---|
| | |

**Medicare number** **ref.** **Expiry**

**HCC / Pensioner / DVA** (please cirlcle)

**Expiry Date** / /

**Private health care fund & no.**

**Account payer details** *(if different from above)*

Name

Contact phone number

DOB

Medicare number Ref. Expiry

**Occupation**

**Next of Kin**

**Emergency Contact**

Name

Relationship

Contact Phone no.

**PLEASE TURN OVER FOR SIGNATURE**

**CONSENT TO COLLECTION OF PERSONAL AND HEALTHCARE INFORMATION**

As a patient of this 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 of your health information at all times. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information and making a complaint about a breach of your privacy.

We require your consent to collect your personal information, and its use for the following reasons:

- Administrative purposes
- Billing purposes (including compliance with Medicare and Health Insurance Commission requirements)
- Disclosure to others involved in your healthcare. This may include allied health professionals, other specialists and health practitioners outside of this practice. This may occur through referral to others or for medical tests and in the reports or results returned to us following referral.
- For research and quality improvement purposes to improve individual and community health care and practice management (this will only be information that does not identify individual patients)
- To comply with regulatory or legislative requirements such as notifiable diseases or where the health and well-being of you or other/s is at significant risk of harm.
- For reminders and recalls which may be sent to you sms, email or letter regarding your healthcare and management.

***You can decline to have your health information used in all or some of the ways outlined above, but it may influence the practice's ability to manage your healthcare to provide the best outcome.***

| ***PLEASE READ EACH STATEMENT CAREFULLY AND TICK THE BOX IF YOU AGREE*** | |
|---|---|
| I have read the information above and understand the reasons why the 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 or if I provide information but want to put limitations on access or disclosure, I will discuss these with the practice beforehand. | |
| I am aware of my rights to access information collected about me, except in circumstances where access may be legitimately withheld. I understand I will receive an explanation in these circumstances. | |
| I understand that if my information is to be used for any other purposes other than those set out above, my further consent will be obtained. | |
| I consent to the handling of my information by the practice for the purposes set out on this form. | |
| I understand that depending on the age of my child, and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare. | |
| I understand that if I request access to information held about me, I may be charged a fee to cover the administrative costs in providing access. | |
| I consent to be sent reminders by sms, email or letter. | |
| **OR** | |
| I am unsure and would like to discuss further with someone from the medical practice before signing | |

Patient name: _____ Date: _____

Patient / Parent / Guardian signature: _____