New patient registration

STIRLING CENTRAL
Health Clinic

Personal details

Title | Family Name | Given name | Middle name | Preferred Name

Date of birth (dd/mm/yy) | Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Unknown | Gender Indentity | Pronouns

Cultural background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

☐ Other cultural background (eg Mediterranean, Asian, African)

Contact Details

Home address | Postcode

Postal address | Postcode

Home number | Work number | Mobile number

Email

Medicare and Concession Details

Medicare card number | Medicare reference number | Medicare card expiry date

Pension, Health Care Card, or Veterans Affairs number (if applicable)
(Seniors Commonwealth Health Card Not Accepted) | Type of Veterans Affairs card | Expiry date

Health Ins. Fund | Health ins. number | Health Ins card expiry date

Head of Family (if patient is under 16)

Title | Family Name | Given name | Middle name | Preferred Name

Date of birth (dd/mm/yy) | Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Unknown

Medicare card number | Medicare reference number | Medicare card expiry date

Who is the next of kin?

Name | Relationship to you

Telephone number | Work number | Mobile number

Who do we contact in an emergency?

Name | Relationship to you

Telephone number | Work number | Mobile number

New patient registration continued...

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Allergies and medicines

List allergies and intolerances to medications

Describe your reaction

List regular medications and doses, and complementary medicines and doses

Consent for 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 understad the reasons why the information must be collected and I consent to the handling of my information by the practice for the purposes set out on this form.
- ☐ 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 understand that if my information is to be used for any other purposes other than those set out above, my further consent will beobtained.
- ☐ 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 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

Signature of patient or guardian

Date

/ /

Transfer of health information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact information or Medicare details change.