BURPENGARY EAST MEDICAL CENTRE & SKIN CANCER CLINIC

New Patient Registration Form

Please take a few moments to read and complete the following pages,
We need this information to provide you with the best quality care.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records allowing us to contact you promptly regarding referrals, tests and results.

SECTION A: Personal Details

TITLE: _____ FAMILY NAME: _____ GIVEN NAME:_____

MIDDLE NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH (dd/mm/year): _____ GENDER: Male ☐ Female ☐ GENDER IDENTITY: _____

MARITAL STATUS: Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐ PRONOUNS: _____

OCCUPATION: _____

ADDRESS: _____SUBURB:_____POSTCODE:_____

POSTAL ADDRESS: _____SUBURB:_____POSTCODE:_____

☐ HOME PHONE: _____ ☐ WORK PHONE: _____ ☐ MOBILE: _____
Please tick preferred contact number above.

EMAIL:_____

HOW DID YOU HEAR ABOUT US? _____

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

Country of Birth: _____ Year of Arrival: _____ Ethnicity: _____

Are you of Aboriginal or Torres Strait Islander Origin? No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐

Languages Spoken : ☐ English Other : Please state : _____ Do you require and Interpreter ? ☐ Yes ☐ No

MEDICARE CARD NO.: ☐☐☐☐☐☐☐☐☐☐ REF NO: ☐ EXPIRY DATE: ☐☐/☐☐

PENSION CARD TYPE: Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card ☐

PENSION/HCC NO.: ☐☐☐☐☐☐☐☐☐☐ EXPIRY DATE: ☐☐/☐☐/☐☐

DVA NO.: ☐☐☐☐☐☐☐☐☐ DVA Card Colour: Gold ☐ White ☐ Lilac ☐ Orange ☐

If your DVA card covers certain conditions, please state condition(s): _____

_____

NEXT OF KIN (NOK) DETAILS (e.g. relation or family member):

Name of NOK:_____ Relationship to you:_____

Contact No: _____

EMERGENCY CONTACT (e.g. friend/neighbour, someone local).

Name of *'Emergency Contact'*:_____ Relationship to you:_____

Contact No: _____

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Medication & Consent Form

Current Medications: (please list all prescribed and natural remedies)

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Natural Remedies: _____

Please note you can provide your own list of medications if you take more than four medications.

Patient Consent

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.

The information we collect may be collected by several different methods and examples may include 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).

By signing, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

Administrative purposes in the operation of our general practice.
Billing purposes, including compliance with Medicare requirements.
Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
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.
Please complete the form 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 permission for my personal information to be collected, used, and disclosed as described above, including contact via SMS to my mobile phone number. I understand 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 am aware a NO SHOW fee of $40 applies, if I do not attend or cancel my appointment within 24 hours of my appointment time, payment is required prior to booking any further appointment. Non-payment will result in debt referred to Debt collection agency and I agree to pay for the cost of the additional charges.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print) _____

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