FRENCHS FOREST DOCTORS

New Patient Registration Form

Please take a few moments to read and complete the following two pages,
We need this information to provide 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 and allow us to contact you promptly about tests and results.

SECTION A: Personal Details

TITLE: _____ FAMILY NAME: _____ GIVEN NAME:_____

MIDDLE NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ / _____ / _____ GENDER: Male ☐ Female☐ Other ☐

CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.
Do you identify as Aboriginal or Torres Strait Islander?

No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐

Do you identify as someone from a culturally and/or linguistic diverse background No ☐ Yes ☐
If yes, do you require an interpreter service?

Country of Birth:

ADDRESS: _____

SUBURB: _____POSTCODE: _____

POSTAL ADDRESS: _____

SUBURB: _____POSTCODE: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____
EMAIL:

OCCUPATION: _____

MEDICARE CARD NO.: ☐☐☐☐☐☐☐☐☐☐ REF NO. (PLACE ON CARD): ☐

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: _____

NOK Address: _____

NOK Contact No: _____ Mobile No: _____

EMERGENCY CONTACT & PHONE NUMBER_____

PLEASE TURN OVER

SECTION C: Medical History

Do you have any known allergies? (E.g. medication, food, bees etc.): Yes ☐ please provide details below No ☐

Smoking Status: Non-Smoker ☐ Smoker ☐ Ex-Smoker ☐

PRODUCT/CAUSE	REACTION	SEVERITY

ADMINISTRATION USE ONLY
The above allergies & smoking details have been entered into the patient record Nurse Signature: _____

SECTION D: Important Practice

PLEASE NOTE: **Frenchs Forest Doctors is a Private Practice.**
BULK-BILLING IS ONLY OFFERED FOR Children under the age of 6 years

Payments can be made by cash, eftpos or credit card.
If you require any further information regarding cost of these please ask reception staff.

Privacy:
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 a number of 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). The personal information collected is that deemed necessary to best attend to and treat the presenting health condition(s). Personal information is primarily used within the practice, but sometimes it is used to ensure quality and continuity of health care for you and must be partially or fully disclosed to others outside of the organization, depending on the circumstances. e.g.: when referring to a specialist medical practitioner or when requesting blood tests, urine tests, x-rays etc.; when itemizing accounts for Medicare.

By signing below, 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.

Freedom of information:
All patient files that include personal information, test results etc. are the property of this practice. However, should you choose to visit another Doctor at any time, copies of the appropriate files can be forwarded on receipt of your written request. Under no circumstance will this practice divulge personal information without your prior written consent.

I have read & understand all information provided above regarding fees, privacy & freedom of information.
I also am aware that at the conclusion of all consultations there will be a request for full payment of the account.

NAME:	SIGNATURE:	DATE: