NEW PATIENT REGISTRATION FORM

To be completed by each individual

PATIENT DETAILS

Title:	Given name:	Surname:	Middle name:	Preferred name:
DOB:	Age:	Sex:	First language:	Occupation:

Home address:	Suburb:	Postcode:
Mobile:	Home:	Email:
Next of kin:	Relationship:	Next of kin's phone no:

How did you hear about us? ☐ Dr referral ☐ Internet search ☐ Friend/family ☐ Facebook ☐ Forums ☐ Other:

Do you consent to receiving email communication (related to your health) and SMS appointment reminders? ☐ Yes ☐ No

GENERAL DETAILS

Medicare no:	Issue no:	Expiry:

Private health insurance? ☐ No ☐ Yes If yes, name of fund: Membership no:

Health care card holder? ☐ No ☐Yes If yes, HCC/Pension No:

REFERRING DOCTOR		**GP** ☐ Same as referring doctor ☐ Other *(give details below)*	
Name:		Name:	
Address:		Address:	
Suburb & postcode:		Suburb & postcode:	
Phone no:	Provider no:	Phone no:	Provider no:

PRIVACY INFORMATION CONSENT & FEE STRUCTURE

The primary purpose this practice collects your personal and health information is to ensure that you receive the best possible care, treatment as well as for us to manage the operations (administrative, planning, service development, quality control) of the practice efficiently. To do so, we may disclose your information to your referring/treating doctors, other healthcare professionals/providers and any regulatory body or third party where legally required. Your information is handled in accordance with the practice's Privacy Policy and any applicable privacy laws.

Patient's acknowledgment

1. I have read this form and understand the purposes for information collection. I am also aware that this practice has a privacy policy in patient information handling.
2. I understand that I am not obliged to provide any information requested. In this regard, non-provision of such information may restrict/inhibit the practice's ability to provide the quality of care and treatment requested.
3. **(FOR COUPLES) I understand that fertility patient's records are "joint records" containing both partners' details. I understand that my information may be disclosed to my partner without my further consent *unless* I explicitly inform the practice in writing.**
4. I am aware that I have the right to access my information collected by this practice, except in some circumstances where explanation will be provided if information is legitimately withheld.
5. I understand that if my information is to be used for any other purposes other than set out above, my further consent will be obtained.
6. I acknowledge that I have read this form before signing and a member of this practice has at my request clarified aspect(s) that I did not understand (if any).

Fees structure: I understand that the consultation fee is in excess of the Medicare rebate amount. I agree to pay the excess amount ("out of pocket/gap payment") at the time of consultation. To be eligible for Medicare rebate, I understand that a valid referral letter from GP/Specialist is required.

Signature of patient:	Name of patient:	Date: