Southland Medical Centre Patient Registration Form

Please complete form in block letters and return to reception

To be completed by persons 16 and over:

Title: Mr / Mrs /Ms /Miss **Gender: ☐ Male ☐ Female**

Surname: _____ Given names: _____

Date of Birth: _____ /_____ /_____ Age: _____

Home Address: _____

_____ Postcode: _____

Postal Address: _____

Mobile: _____ Home Phone: _____ Work Phone: _____

Email: _____

Emergency contacts / Parent or Guardian (If spouse please give alternative phone number if possible, or list a 2nd emergency contact). Contact Name: _____

Contact Number: _____

Medicare Card No: _____ Reference no. (e.g. 1,2): ____ Expiry date: ___ /___ /___

Centrelink HCC/ Pension No: _____ Expiry date: ___ /___ /___

DVA No: _____ Expiry date: ___ /___ /___

Are you an Aboriginal person or Torres Strait Islander? ☐ YES ☐ NO

Do you wish to identify with a particular culture? Australian/English/Chinese/Indian/Other:_____

How did you find out about us? webpage/word-of-mouth/web-search/social-media/flier/other:_____

Please complete if patient is under 15 and accompanied by parent or guardian

Child's Surname: _____Given Names:_____

Date of Birth: ____ /____ /____ Gender: ☐ Male ☐ Female

Medicare number: _____ Reference no. (e.g. 1,2): _____ EXPIRY DATE: ____ /____ /____

Reminder Systems: Our practice automatically provides patients with preventive care and early case detection reminders e.g. Immunisations, annual health checks, skin checks and cancer screenings.

- Do you consent to SMS communication for recalls, reminders and appointments? **(YES)** **(NO)**
- Do you consent to email communications from our practice? (**YES)** **(NO)**

Phone Authority: We might need to phone you regarding an appointment you have made or a message from the doctor to return our phone call. If you are unavailable, do you authorise us to leave a message:

- on your mobile answering service? (**YES)** **(NO)**
- on your home telephone answering service? (**YES)** **(NO)**
- with an individual contactable by the phone numbers you have provided (e.g.: family member) (**YES)** **(NO)**

Our practice is a fee-paying clinic. The full fee must be paid for the consultation. The Medicare rebate is applied after payment. Accounts referred to a debt collection agency or solicitor will incur a debt collection fee.
The patient will accept full liability for all **WorkCover** and **TAC** claims.
Privacy Policy: We are committed to maintaining the confidentiality of your personal information in keeping with the Privacy Act, 2001. It is clinic policy to maintain the security of personal health information at all times, and to ensure that this information is only available to authorised practitioners and staff. Information may be disclosed to other organisations where required by law or if necessary contact details may be disclosed for billing or debt recovery purposes. Please request our Privacy Policy for more information.

I consent to the retrieval and distribution of medical information, including reports and results from medical tests, from and to others involved in my health care, including treating doctors, specialists, hospitals and other health care facilities outside this medical practice. I consent to my de-identified data to be used for NHMRC government approved quality improvement and research activities, and for secondary purposes of data-quality, service planning and population health planning.
(To be signed by the patient or guardian/care-giver)

SIGNATURE_____ DATE ____ /____ /____