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OFFICE USE: ID type: _____		
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Southland Medical Patient Registration Form

Please complete form in block letters and return to reception
To be completed by persons aged 16 and over.

Title: Mr / Mrs / Ms / Miss / Mx / Other: _____ Surname: _____
Given names: _____ Date of Birth: ___/___/___ Age: _____

Gender & Identity

Your sex recorded at birth:

Female Male Another term: _____ Prefer not to say

How you describe your gender:

Female Male Non-binary Gender diverse Prefer not to say Transgender

Contact Details: Home Address: _____

Postcode: _____
Postal Address: _____
Mobile: _____ Home Phone: _____ Work Phone: _____
Email: _____

Emergency contacts / Parent or Guardian (If spouse, give alternative phone number, or 2nd emergency contact).

Contact Name: _____ Contact Number: _____ Relationship: _____

Next of Kin

Contact Name: _____ Contact Number: _____ Relationship: _____

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

Centrelink HCC/ Pension No: / 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: _____

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 to protect your health. We send reminders by post, telephone, emails or SMS for your appointments e.g. immunisations, health checks, skin checks and cancer screenings.

Do you consent to SMS/Emails communication for recalls, reminders and appointments? (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 unavailable, do you authorise us to leave a message:

- on an answering service? (YES) (NO)

- with someone 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 on the day. 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 1988 (VIC) and the Health Privacy Principles which apply pursuant to the Health Records Act, 2001 (Vic) (Health Records Act).

It is clinic policy to always maintain the security of personal health information, and to ensure that this information is only available to authorised practitioners and staff. Your information will be used for: **administration purposes for running the practice; billing purposes including complying requirements of Medicare and the Health Insurance Commission; quality assurance activities and research purposes such as accreditation (patient identity will not be disclosed; for infectious disease notification as required by law; for legal purposes (e.g. Subpoena or Court Order); disclosure to others involved in your health care such as doctors or allied health professionals for the purpose of patient care; and for sending prescriptions electronically where requested, and may view the history of any of your prescribed or dispensed prescriptions.**

Please request our Privacy Policy for more information.

Patient Consent

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 ____ / ____ / ____