Western Clinic Medical Centre

PATIENT REGISTRATION FORM

Today's Date: _____/_____/_____

Title: Miss Mr Mrs Ms Other Given Name (s): _____ Surname: _____

Date of Birth: _____ To which Gender do you most identify: _____

Street Address: _____

Suburb: _____Post Code: _____

Postal Address: _____ Post Code: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

Email: _____Occupation: _____

Medicare no: _____ Ref no on card: _____ Expiry date: _____/___/____

Emergency Contact Name: _____Phone: _____ Relationship: _____

Next of Kin Contact Name: _____Phone: _____ Relationship: _____

Pensioner/ Health Care card No: _____ Expiry date___/___/___
:
Department of Veterans Affairs No: _____ Card Colour: _____

Do you identify as an Aboriginal or Torres strait Islander: yes/no
-
Cultural background? _____ Is an Interpreter required? Yes/No Language: _____

Are you a Parent or Guardian: YES /NO name: _____ Relationship to patient _____

Please Sign Here: _____

PRIVACY CONSENT:

Amendments to the Privacy Act came into effect in December 2001. As a provider of healthcare
services it is important that you are aware of how any personal information collected by this practice is used.
The personal information collected is that deemed necessary to best attend to and treat the presenting health condition(s).
Personal information is primarily used internally 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 the organisation, depending on the circumstances.
eg: when referring to a specialist medical practitioner or when requesting blood tests, urine tests, Xray's etc. when itemising accounts for Medicare.
I give permission for the uploading of MyHR/Personally Controlled Health Record to Dept of Health.
I am aware that I can request this be withdrawn at any time.

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 file(s) can be forwarded on receipt of your written request.
Under no circumstance will this practice provide or transfer personal information without your prior written consent.
I consent to my medical record being emailed to authorised medical practitioners.
I am aware it is my responsibility to pay any fees associated to my consult.

Please read and sign your acknowledgement below:
I have read and understand all information provided above regarding fees, privacy, and freedom of information.

Name: _____

Signature: _____ Date: ____/_____/_____