PATIENT REGISTRATION FORM Western Clinic Medical Centre

Please take a few moments to read and complete the following

Todays Date: _____/_____/_____

Title: miss mr mrs ms other Surname: _____ Given Names:_____

Date of Birth:_____ Gender:_____

Street address:_____

Suburb and postcode:_____

Postal address:_____ post code:_____

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

Email:_____ Occupation:_____ Student ID:_____

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

NO MEDICARE CARD? IMPORTANT PLEASE READ
Patients with no medicare card are responsible for full payment of the account at the time of consultation with the doctor.
Please show ID evIdence of student card or concession to be charged Medical Benefits only. I f you have Private Health insurance as an overseas visitor check that you are able claim a rebate.

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

Emergency Contact:_____ Phone:_____ Relationship:_____

Do you identify as an Aboriginal or Torres strait Islander : yes/no
-
English speaking background? Yes / No If no, please specify:_____ Is an Interpreter required?_____

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

Please Sign Here:_____

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Information about fees: EFTPOS facilities are available

Missed Appointments: If you are unable to keep your appointment, please notify us immediately.

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, Xrays 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I am aware that I can request this be withdrawn at any time.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.
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:____/_____/_____