FOUNTAIN GATE MEDICAL CENTRE
PATIENT REGISTRATION

Surname: _________________ Title: _____ First Name:_______________
Date of Birth: ____/_____/____ Male / Female Aboriginal/Torres Strait Islander? Yes/No
Country of Birth/Ethnicity ____________________________
Address: ____
Suburb: _______________________________________ Post Code: ______________
Phone: h) ______________ w) ______________ Mob) _________________
Medicare No: __________________________________ Exp: ____/____ Ref no: ________
HCC/Pension No: ___________________________________ Exp: ____/____
DVA: _______________________________________ Exp: ____/____
Person to contact in event of emergency: _______________________ contact no. if different: ___________
Relationship to you? _________________________________
Address: ____
Suburb: _______________________________________ Post Code: ___________________

Could you please note down how you found out about our clinic.
Sign at front □ Google □ Yellow Pages □ On-line Yellow Pages □ Referred by other patient □
Our Website □ Other__________

PATIENT PRIVACY CONSENT FORM

In accordance with National Privacy Principles, we are required to record your consent to enable us to collect and handle personal information about you.
Please read the **Privacy Policy** carefully, and sign where indicated below.

Privacy Policy

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with accurate and up to date personal details and a full medical history so that we may safely and properly manage your health care needs.
We may use the information you provide to us in the following ways:
Administrative purposes in running our practice
Billing purposes in compliance with Medicare and HIC requirements
Disclosure to others involved in your healthcare, including specialists and other health care providers outside this medical practice. This may be in the form of referral letters and/or by collecting de-identified statistical information for clinical audits used for improved health care.

Send recall and reminder letters, sms and phone calls. Please tick this box if you **do not want to receive these reminders**. ☐
This medical practice complies with the National Health Privacy Principles in collection, storage and transfer of your personal information.

Patient Declaration

I have read and understood the information above, the information above.
I understand that I am not obliged to provide and any information requested of me, but that failure to do so might compromise that quality of the health care given to me.
I undertake to notify the practice of changes to my personal details.
I am aware of my right to access the information collected about me, except in legitimate circumstances that will be explained to me should they arise.
I understand that if my information is to be used for any other purpose other than that set out above, my further consent will be obtained.
Any limitations that I place on the handling of my personal information, I undertake to set out in writing.

The doctors at Fountain Gate Medical Centre take your health seriously.
There is often the possibility that your illness may indicate a serious disease, and your Doctor may request tests such as Xrays or blood tests to check for the possibility of a serious problem.
It is therefore important that if the doctor requests blood tests, xrays or other tests, that you have these performed as requested. By signing this you agree to have the tests that the doctor requests and follow up about the results of these tests from the clinic.

Signature of Patient or Guardian: _____________________________________
Name Printed in full: __________________________________Date: _____________
Witness: ____