PATIENT REGISTRATION

Surname:_____DOB:_____
Name:_____Male/ Female
Mr ⊡ Mrs □ Ms □ Miss □ Master □ - Please Circle
Address:_____
Suburb: _____ Post Code: _____

Phone: H) _____ W) _____ Mob) _____

Medicare No: _____ Exp: ____/_____ Ref No: _____

Pension /HCC No: _____ Exp: __/___/____ DVA: _____

Are You Aboriginal/Torres Strait Islander? Y/N Ethnicity: _____
Next of Kin: _____Relationship:_____Ph:_____
Person responsible for account: _____
Past illness: _____
Allergies: _____

HOW YOU FOUND OUT ABOUT OUR MEDICAL CENTRE? **Sign at front □ Google □**
Yellow Pages □ On-line Yellow Pages □ Referred by other patient □ Facebook □
Fountain Gate Medical Centre ◪ Other_____

PATIENT PRIVACY CONSENT FORM

In accordance with Privacy 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:

- By all doctors in this group practice when consulting with you
- Administrative purposes in running our practice
- For reminder / recall notices
- Billing purposes in compliance with Medicare 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 and for My Health Record.
- Quality Assurance activities such as accreditation
- For disease notification as required by law (e.g. infectious diseases)
- For legal related disclosure as required by a court of law (e.g. subpoena, court order, suspected child abuse)

This medical practice complies with the Australian Privacy Principles in collection, storage and transfer of your personal information.

Patient Declaration

I have read and understood the information above.
I understand that I am not obliged to provide any information requested of me, but that failure to do so might compromise the 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.

Signature:_____

Name Printed in full: _____Date: _____