PEARCEDALE MEDICAL CENTRE

REGISTRATION FORM FOR NEW PATIENTS

Title: Surname: First name:

Your preferred name:

Date of birth: / / Male Female

Aboriginal or Torres Strait Islander? Male Female

Ethnicity: Country of Birth:

Address:

Suburb Postcode:

Home phone: Work: Mobile:

Do you consent to using SMS as a method of communication to remind you of your appointment? Yes No

Are you happy to receive emails from us? Yes No

If so, please provide your email address:

Medicare number: Line number: *(Next to name)* Exp date: /

Healthcare card Pension card: Number Exp date: /

Veteran affairs number: Colour: Exp date: /

Emergency Contact person Name:

Contact Number: Relationship:

Do you visit a regular Pharmacy? Yes No If so which one:

We would love to know how you heard about us?
(*eg: Family member / Friend / HealthEngine / Internet/Website, Advertising Material)*

PATIENT CONSENT AND PRIVACY AGREEMENT

I have read this practices privacy policy and understand the reasons why my information must be collected. I understand that I am not obliged to provide information requested of me, but that my failure to do so might compromise the quality of the healthcare and treatment given to me.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out in the privacy policy, subject to any limitations on access or disclosure that I notify this practice of. I consent to be included in your clinics recall reminder system, receive health information updates and medical updates and be involved in state/national recall reminder register.

I understand that in order to facilitate the provision of integrated healthcare services all relevant medical and allied health involved in my care will have access to my medical record and give my permission for the information to be shared as detailed above.

Please print, sign and return.

SIGNATURE:

PRINT FULL NAME: DATE: / /