Reset

PEARCEDALE MEDICAL CENTRE

REGISTRATION FORM FOR NEW PATIENTS UNDER 15

Title: _____ Surname: _____

Child's preferred name: _____

Date of birth: _____ / _____ / _____ Male ☐ Female ☐

Does child identify himself/herself as Aboriginal or Torres Strait Islander? Male ☐ Female ☐

Ethnicity: _____ Country of Birth: _____

Address: _____

Suburb _____ Postcode: _____

Home phone: _____

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

Child's Next of Kin Name: _____ Contact Number: _____

Relationship to Child: _____

Emergency contact person name (*if different to Next of Kin*): _____

Contact number: _____ Relationship to child: _____

Who is responsible for payment of accounts? (*Name of parent/guardian responsible for account*)

Name: _____ Contact number: _____

Relationship to Child: _____

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: _____ / _____ / _____