



Registration Form

As you are providing us with health information, please also read and sign a consent for to allow us to collect and use your health information.

Personal Details		
Titles	Gender	Date of Birth
First Name	Middle Name	Surname
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Engaged <input type="checkbox"/> Divorced <input type="checkbox"/> De Facto <input type="checkbox"/> Widowed		
Address		
Phone	Work	Mobile
Email Address		
Medicare Number	IRN	Exp
Pension No	Exp	DVA No
Private Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		
Aboriginal / Torres Straight Islander <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current Occupation		
Previous GP Details		
Next of Kin Name	Relationship to you	
Next of Kin Contact Details		
Emergency Contact	Relationship to you	
Emergency Contact Details		
Do you have any allergies to medicines or anything else? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list		
Cigarettes <input type="checkbox"/> Non Smoker <input type="checkbox"/> Ex Smoker <input type="checkbox"/> Current Smoker		
Alcohol <input type="checkbox"/> NIL <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy		
Can we update a shared health summary to your My Health Record quarterly <input type="checkbox"/> Yes <input type="checkbox"/> No		
Can we contact you via text about appointments, reminders and preventative health <input type="checkbox"/> Yes <input type="checkbox"/> No		



Health Information Collection and Use Consent Form

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually, information that does not identify you is used but should information that will identify you be required, you will be informed and given the opportunity to “opt out” of any involvement.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.
- For the periodic update of a shared health summary in your My Health Record (unless you have already opted out of).
- Our Clinic sends information to the Australian Immunisation Register.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	
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 the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	

Patient's Name		Patient's Signature	
Guardian's Name		Guardian's Signature	
Date			