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**NEW PATIENT**

**REGISTRATION FORM**

We are committed to providing our patients with the best possible care.

To do this it is essential that your records are kept up to date. Please notify us of any changes ASAP.

**We request that all clients contact us by phone for their pathology results unless advised otherwise.**

|  |  |
| --- | --- |
| Title |  Mr Mrs Miss Other:  |
| Surname |  |
| First Name/s |  |
| Preferred Name |  |
| Date of Birth |  |
| Sex | Male/Female |
| Email |  |
| Street Address |  |
| Suburb and Postcode |  |
| Home Phone |  |
| Work Phone |  |
| Mobile phone |  |
| Medicare Number & Ref | No: Ref No:Expiry date:**Please give card to receptionist to sight** |
| Pension Number | Full/Part No: Expiry: |
| Concession Card | Health Care Card/ Commonwealth Seniors CardNo: Expiry:**Please give card to receptionist to sight** |
| DVA White/Gold | No: Expiry:Condition/s (white card only): |
| Private Hospital Insurance | No: Fund: |
| Emergency contact/Next of Kin | Name: DOB:Phone No:Relationship: |
| Knowing your cultural heritage can help us tailor your healthcareDo you identify as: Aboriginal Yes No Torres Strait Islander Yes No Other (please specify) ……………………………………………………………… |
| Are you an interstate or overseas visitor to Alstonville? Yes No |
| Do you intend to have ongoing medical care provided by Alstonville Clinic?  Yes No |

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 New Patient Information Form

**Your Privacy is our concern**

In accordance with the Privacy Act, all information collected in this practice is treated as “sensitive information”. To protect your privacy, this practice operates in accordance with this Act.

We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes to your address, phone number, medicare card and next of Kin etc.

Selected information may be disclosed to various other health services involved in supporting your health care management. (e.g. pathology & radiology providers, immunisation registers, specialist or community health referrals etc).

If you have any questions or concerns regarding how we handle your personal health information or would like to arrange access to your records, please talk to our staff or your doctor, as appropriate. I understand the practice may charge a fee to cover time and administration costs which may not be covered by medicare.

**Health Information**

We encourage our patients to be pro-active in their health care and to help with this we will from time to time send you information regarding any health initiatives we feel you may benefit from.

From the 1st July 2012 every Australia can choose to register for a Personally Controlled Electronic Health Record.My Health Record (MyHR),your eHealth record will contain a summary of important health events and current medications. This will be accessible online – **with your permission** – to Hospitals, Specialists and even another doctor if you are travelling.

 I am interested in registering for a MyHR

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understand all of the above and consent to the handling of my information by this practice for the purposes set out above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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**Authority to release**

I/We:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Of (address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request that doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Of (address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forward a summary of my/our relevant medical history to:

Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Of Alstonville Clinic

61 Main Street

Alstonville NSW 2477

Phone: (02) 6628 0505

Fax: (02) 6628 5627

**We do not require a complete copy of records**

**NO DISCS PLEASE**

Signature: ………………………………………………………………………………….. Date: ……../……../…….