WESTWOOD MEDICAL CENTRE

New Patient Registration Form

A Personal Details

Title ☐ Mr ☐ Mast ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Given Name | Middle Name | Last Name

Preferred Name | Date of Birth | **Gender** ☐ Male ☐ Female

Medicare Number | Reference Number | Expiry Date

Postal Address

Home Phone | Work Phone | Mobile

Email Address

Do you wish to identify yourself as an Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

B Concessions

Pension Number | HCC | Expiry Date | DVA

C Emergency Contact

Next of Kin | Relationship | Phone

Emergency Contact Name | Relationship | Phone

D Ethnicity

Country of Birth | Year of Arrival in Australia | Ethnicity (Culture, Origin) | Spoken Language

E Health Information

Allergies or Sensitivities | Medical Conditions or Disabilities

Childhood Immunisation completed? ☐ Yes ☐ No

Are you an overseas student with a BUPA Card? ☐ Yes ☐ No

Year of last tetanus injection | BUPA No. | Expiry Date

Do you require an interpreter? ☐ Yes ☐ No If so, language required _____

F Authorisation

Would you like to receive reminders about periodic health checks, e.g. diabetic reviews, immunisations, pap smears etc. ☐ Yes ☐ No

Are you happy for us to send you reminders via SMS? ☐ Yes ☐ No

How did you hear about us? ☐ Word of Mouth ☐ Google ☐ Our Website ☐ Health Engine ☐ Flyer ☐ Other _____

Signature | Date

WESTWOOD MEDICAL CENTRE

Health Information Collection & 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, Allied Health Professionals and specialists outside this medical practice. This may occur though 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 and Allied Health Professionals 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 e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

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 understand that depending on the age of my child (16 and over) and given my child's right to privacy, in the clinical judgement of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	☐
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

Date

Signed as guardian for child

Name (Printed)