EAST KEILOR CLINIC NEW PATIENT REGISTRATION

When completed, please return this form with your Medicare Card, Pension Card, Veterans' Card or Health Care Card to reception.

TITLE: MR MRS MISS MST MS

FIRST NAME: ________________**KNOWN AS:** _____________

SURNAME: ____________________________________

D.O.B: _______________________**SEX:** MALE/FEMALE

ABORIGINAL/TORRES STRAIGHT ISLANDER: YES/NO

COUNTRY OF BIRTH ________________________________

MEDICARE NO: ____________________**REF NO:** _____

EXPIRY DATE: _____

CONCESSIONS: HCC / PENSION / VET AFFAIRS

ENTITLEMENT NO: __________________________________

PRIVATE HEALTH INSURANCE: YES/NO

HEALTH FUND: _______________________________________

ADDRESS: ____

POSTCODE: _________**HOME PHONE:** __________________

WORK: _____________**MOBILE:** ________________________

PREFERRED CONTACT NO: _____________________________

NEXT OF KIN DETAILS & CONTACT NUMBERS FOR EMERGENCIES: ____

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ALLERGIES: ____

PAST MEDICAL HISTORY: ______________________________

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CURRENT MEDICATIONS: ______________________________

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I CONSENT TO THE HANDLING OF MY INFORMATION BY THIS PRACTICE FOR THE PURPOSES SET OUT IN THE PRIVACY POLICY (OVERLEAF).

SIGNED: _____________________________ DATE:

PRIVACY POLICY IN BRIEF:

We require your consent to collect information about you. Please read this information carefully, and sign on the front page.

This medical clinic collects information from you to provide quality health care. 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. This means we will use the information you provide in the following ways:

- Administration purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, 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 use following referrals. Also for other registration purposes such as the childhood Immunization register.
- Disclosure to other doctors in this practice for the purpose of patient care.

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I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care treatment given to me

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I have read the information above and understand the reasons why my information must be collected.

I am aware of my right to access the information collected about me except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

Agreement signature on the front page.