NEW PATIENT REGISTRATION FORM

Mr / Mrs / Ms / Miss **Surname:** _____
(Please circle)

Given Name: _____

Date of Birth: __ __ /__ __ /__ __ __ __ **Gender**: Male ☐ Female ☐ Other _____
Do you identify as: Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Other _____

Address: _____

Suburb: _____ **Postcode:** _____

Home Phone: _____ **Mobile**: _____

Would you like SMS reminders? Yes ☐ No ☐

Email address: _____
I consent to receive email communication regarding my medical care: ☐

How would you like e-scripts sent to you? Smart Phone ☐ Email ☐ Paper ☐

Do you require a translator? ☐ Yes ☐ No

Medicare number: __ __ __ __ __ __ __ __ __ __ __ Ref no: __ Expiry Date: __ __ / __ __ __ __

Please Tick Type of Pension Card: Disability ☐ Single Parent ☐ Seniors ☐
Pension Card Number: __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ /__ __ / __ __ __ __

Health Care Card Number: __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ /__ __ / __ __ __ __

DVA: _____ Gold ☐ White ☐ Please write conditions: _____

Do you participate in the National Disability Insurance Scheme: Yes☐ No ☐

Private Health Insurance Fund: _____

Health Insurance Number: __ __ __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __ /__ __ / __ __ __ __

Next of Kin:
Name: _____
Address: _____
Suburb: _____ Post Code: _____
Phone: _____
Relationship: _____
Mobile number: _____

Emergency Contact/ Same as Next of Kin ☐
Name: _____
Address: _____
Suburb: _____Post Code: _____
Phone: _____
Relationship: _____
Mobile number: _____

Occupation: _____

Marital Status: _____

How did you hear about us: _____

I agree to pay all accounts on the day of consultation.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Health Information Collection and Use Consent Form

At First GP Wallsend, we collect personal and health information about individuals for the principle purpose of helping patients manage their health and improving patient health outcomes. We require you to provide us with your personal details and a full medical history so that we can properly assess, diagnose, treat and be proactive in your healthcare needs.

We may disclose personal and health information to other health care providers in line with our principle purpose and for research and quality assurance activities to improve individual and community health care and practice management. Some information is collected as part of the necessary process of running a business in Australia, 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.

Further, we are required to use various government identifiers. For patients, these identifiers include Individual Healthcare Identifiers (IHI), Medicare card numbers, Department of Veterans Affairs (DVA) file numbers, concession card details, and Safety Net Numbers.

We may use your personal information and disclose about you to various government departments and other entities for billing those entities for the health services that we provide to you.

You can obtain our privacy policy on the FirstGP website or 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. 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.

If you request in writing for information to be disclosed to third parties, we may elect to do that, and we may charge the third party for this information.

- I take full responsibility to provide accurate information and update urgently if any changes to the information occur.
- 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 that 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 give consent to be part of national recall and reminder programs such as bowel screening, breast and cervical screening, etc.
- 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.

Patients Name: ……..

Signature: ……..

If patient is under 16 years of age, a signature from parent/ guardian is required.

Reception Confirmation:

Billing Class: International ☐ Private ☐ Pension ☐. Explained to patient? Yes ☐ No ☐