Walker Street
GENERAL PRACTICE

NEW PATIENT REGISTRATION FORM

This form is to be filled in by patients over the age of 14. Parents/guardians will need to fill in the below form for those under 14 years. Photo identification will need to be sighted at initial registration before you are seen by the Doctor.

GENERAL INFORMATION – WRITE YOUR NAME AS PER MEDICARE CARD	
Title:	Surname:
First Name:	Middle Name:
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other ☐ Not Stated
Medicare Number: _ _ _ _ _ _ _ _ _ _ (10 Digits) Ref No: _ _ Expiry: _ _/_ _ _ _	
To assist with health initiatives – Are you of Aboriginal or Torres Strait Islander origin?: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither	
Ethnicity:	
Pension/Health Care Card: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Expiry: _ _ _ _/_ _ _ _ Dept. of Veterans' Affairs: _ Gold/Orange/White	
Street Address:	Suburb & Postcode:
Postal Address: *(if different from above)*	
Home Phone:	Work Phone:
Mobile Phone:	Email: *For Reminders, Health Awareness & Preventative care Information
Next of Kin *(best person for us to contact on your behalf)* Name: Relationship: Phone:	
Emergency Contact: *(name and phone number in the case of an emergency)* Name: Relationship: Phone:	
CONTACT, REMINDERS & RECALLS	
Do you wish to receive Appointment Reminders via SMS? ☐ Yes ☐ No	
The Practice participates in National, State and Territory Recall Programs. Do you consent for us to send SMS reminders to recall you for follow-up procedures? Eg: Breastscreen, Bowel Screening. ☐ Yes ☐ No	

PATIENT CONSENT

We require your consent to collect personal information about you. Please read the below information carefully, and sign where indicated below. A full copy of our Privacy Policy is available at reception.

WSGP collects information from you for the primary purpose of providing 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 and treat illnesses and medical conditions, ensuring we are proactive in your health care needs. This information may be used in the following ways:

- Administrative purposes in running our medical practice;
- Billing purposes, including compliance with Medicare Australia requirements;
- Disclosure to others involved in your health care, including doctors in the practice, 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 the referrals;
- To contact you or your family for the purposes of Recalls & Reminders; and
- De-identified information may be used for statistical purposes and research activities. We undertake quality assurance activities to improve individual and community health care and practice management.

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

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 and treatment given to me.

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.

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 this practice for the purposes set out above.

I also understand that it is my responsibility to contact the practice to obtain any test results. Every effort will be made by WSGP to communicate a significantly abnormal result to you.

Signature of Patient or Parent/Guardian: Date:

Office Use Only
Photo ID sighted: Yes/No Initial: