NEW PATIENT REGISTRATION FORM

Asquith Medical Centre

PLEASE NOTE A MIN FEE OF $80 WILL APPLY FOR NEW PATIENTS. FEES MAY APPLY FOR FUTURE VISITS.

Personal Details (as it appears on your Medicare Card or passport):

Title (please circle): Mr Mrs Ms Miss…… Master
Surname: _____
First Name: _____ Middle Name: _____ Preferred Name: _____
Date of Birth: _____ Country of Birth: _____
Cultural Background:
Australian, non indigenous /Torres Strait Islander but not Aboriginal /Aboriginal but not Torres Strait Islander / Both Aboriginal and Torres Strait Islander / (please circle one) / Other cultural background (i.e., Italian) _____
Address Line 1: _____
Address line 2: _____
Suburb: _____Postcode: _____
Mailing Address If different from above: _____
Home Number: _____ Mobile Number: _____
Occupation: _____
Email Address: _____

MEDICARE / PENSION/DVA/ COMMONWEALTH SENIORS/CARD DETAILS:
Medicare Card Details: _____ Ref N#_____ Expiry_____/ _____
Pension/Concession Card: (Numbers Only) _____ Expiry_____/_____
Veteran Affairs Card: _____ Card Type (please circle): Gold White Orange
Private Health Insurance: Health Fund Member No: - _____ Cover: _____
_____

Consent to received SMS appointment reminders	YES	NO (please circle)
Consent to receive email reminders	YES	NO (please circle)
Consent to be contacted with reminders to help me maintain my health	YES	NO (please circle)

Our practice also sends information to the Australian Childhood Immunisation Register and Cervical Screening Register.

Next of Kin:
Name: _____ Contact Number: _____
Relationship: _____
Who can we contact in case of an emergency?
Name: _____ Contact Number: _____
Relationship: _____

How did you hear about Asquith Medical Practice? (Search engine / family/ friend _____

Health Information Collection & Use Consent Form:
Patients Name: _____ Signed as a guardian for a child: _____
Signature: _____ Guardian's name: _____
Date: _____ Date: _____

Thank you for providing your personal health information to our practice. We undertake to manage this information in a secure manner and to use it only for the purpose of your health care or directly related purposes. You have the right to access your medical record. You have the right to confidentiality. Information will not be disclosed without your consent except in an emergency, or where required by law, or for billing purposes (e.g. Medicare, pathology provider). Referral to other health providers implies consent to disclose personal health information. Copies of prescriptions are routinely sent to pharmacists via the eRX script exchange. Please read our Privacy Policy for more information. By signing below, you are giving consent for the Asquith Medical Centre to hold and use your personal health information for these purposes.

Do you consent to Asquith Medical Centre adding your details to My Health Record/MyMedicare: ☐ **Yes** ☐ **No**