|  |  |
| --- | --- |
| Title (pls circle) | Mr / Mrs / Ms / Miss / Mst / Dr / Prof Gender: M / F / Other |
| Surname (as stated on Medicare Card): |   |
| Given Names: |  Preferred Name: |
| Date of Birth |   |
| Do you self-identify as: | [ ]  No [ ] Aboriginal [ ] Torres Strait Islander [ ]  Both Aboriginal & TSI |
| Ethnicity / Ancestry |  |
| Is English your first language? | [ ]  Yes [ ]  No *If no*, do you require an interpreter? [ ]  Yes [ ]  No  *If yes*, what language?  |
| Relationship Status: | [ ] Married [ ]  Single [ ]  Defacto [ ] Widowed [ ]  Divorced [ ]  Separated  |
| Address: |  |
| Suburb: |  State: Postcode: |
| Phone: | Mobile: Home:  |
| Consent to receive: | SMS messages for test recalls or reminders [ ]  Yes [ ]  No |
| Email *(for medical correspondence purposes only; not marketing):* |  |
| Occupation: |  |
| Medicare No:  |  Ref (# in front of name): Exp:  |
| Centerlink Card *(for Medicare billing purposes)*: | Pension No: Health Care No: Senior’s Health Care No: Exp:   |
| Veteran Affairs No: |  Card Colour: Exp: |
| If BUPA Overseas Student or Visitor:  | Patient ID (# in front of name): Membership No:  |
| Next of Kin: | Name: Phone:  |
| Relationship |  |
| Emergency Contact: | Name: Phone: |
| Relationship |  |
| Can we leave a message regarding your appointment on your voicemail? [ ]  Yes [ ]  No |
| Can we leave a message regarding your appointment with another member of your family? [ ]  Yes [ ]  No |

**NEW PATIENT REGISTRATION / CHANGE OF DETAILS FORM**

 **PATIENT CONSENT FORM**

Reedy Creek Medical Centre requires your consent to collect personal information about you for the primary purpose of providing quality healthcare. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise you on all your health care needs. Please read this consent form carefully.

* **I give consent** for Doctors/Staff to disclose my results and any relevant information that may be needed by another party eg: Specialist or Hospital, for the sole purpose of quality and continuity of care
* **I give consent** for Doctors/Staff to contact Medicare or any other organization on my behalf for the collections of information that may be necessary for the sole purpose of quality and continuity of care
* **I give my consent** for disclosure for research and quality assurance activities to improve individual, community health care and practice management. This may occur when the practice incorporates patient health records into **de-identifiable patient information** to transfer to a third party, normally used for quality improvement projects. **De-identifiable patient information cannot be traced back to the individual.**
* **I acknowledge** that after a consultation with my doctor, if there is an agreed management plan or recommended referral or test, then it is my responsibility to follow-up on these instructions.
* **I acknowledge** that I am responsible for arranging follow-up appointments with my doctor pursuant to any tests to discuss their results. I will not assume that the results are normal if I do not hear from my doctor. If I have any persistent or worsening symptoms, it is my responsibility to make a follow-up appointment.
* **I acknowledge** that it is my sole responsibility, and not that of the practice, to follow-up on health reminders sent by the practice.
* **I understand** that Reedy Creek Medical Centre has an agreement with Health Engine for SMS appointment reminders, as well as recall and health reminders.
* **I understand** that I am free to withdraw my consent at any time by verbal or written consent.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Parent/Guardian (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_