Whitsunday Doctors Service

Patient Registration Form

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐

First Name: _____ *Known as*: _____
(as on Medicare Card)

Surname: _____ **Cultural Needs: yes ☐ no ☐**
(as on Medicare Card) List:

Date of Birth: ___/___/_____ _____

Do you identify as being of Aboriginal and/or Torres Strait Islander origin? yes ☐ no ☐

Aboriginal ☐ Torres Strait Islander ☐ both Aboriginal and Torres Strait Islander ☐

Medicare Card Number: ☐☐☐☐☐☐☐☐☐☐

Reference No: ☐ **Expiry Date:** ☐☐/☐☐☐

Dept. Veteran Affairs File Number: _____

Healthcare Card No:_____ **Expiry:** ___/___/_____

Pension Card No:_____ **Expiry:** ___/___/_____

Private Health Fund Name: _____**Number:**_____

Residential Address:_____

Suburb: _____ **State:**_____ **Postcode:**_____

Postal Address:_____
(If it is the same as Residential, write As Above)

Suburb: _____ **State:**_____ **Postcode:**_____

Home Phone: _____ **Work:** _____

Mobile: _____ **Email:** _____
Do you wish to receive email notifications? Yes / No

Marital Status: _____ **Country of Birth:** _____

Occupation: _____

Next of Kin: _____**Relation:**_____**Ph No:** _____

Contact in case of Emergency:_____ **Ph No:**_____

Do you wish to receive recall/reminder notices? Yes / No

What is your preferred method of notification? Telephone / Post / Email / SMS

Whitsunday Doctors Service

This medical practice 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, 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 us following the referrals.
- Disclosure to the other doctors in the practice including locums attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want you records accessed for these purposes, and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to 'opt out' of any involvement.

All staff employed at Whitsunday Doctors Service is educated in the importance of patient confidentiality and have signed a contract pledging to use the client information only for the health management of the patient.

If you have any concerns please discuss it with one of the staff or ask to speak with the Practice Manager.

I,_____, have read and understand the above.
(FULL NAME)

Patient/Guardian Signature: _____ Date: ____/____/_____

Name of Patient if signed by Guardian: _____