PATIENT REGISTRATION DETAILS

MISS / MSTR / MRS / MR / MS **SURNAME:** _____

GIVEN NAME (S):_____ DATE OF BIRTH: ____/____/_____

ADDRESS: _____

_____POSTCODE: _____

PHONE NO: (H) _____ (W) _____(M) _____

EMAIL ADDRESS:

_____

ABORIGINAL OR TORRES STRAIT ISLANDER? YES / NO

CULTURAL BACKGROUND _____

MEDICARE NUMBER _____Reference Number: ___

PENSION NUMBER _____

EMERGENCY CONTACT NAME: _____

ADDRESS: _____

EMERGENCY CONTACT PHONE NO: (H)_____ (M) _____

DEBTOR DETAILS (WHO WILL BE RESPONSIBLE FOR ACCOUNT) SELF / OTHER

IF OTHER, NAME OF PERSON RESPONSIBLE:_____

DATE OF BIRTH:___/___/___

We do have a recall system in place for reminding patients when certain investigations, assessments or consultations are due.

You may be notified by either SMS, phone call, letter or via email

Do you consent to us contacting you for the above reasons? YES / NO

Authority To Request Medical Information

I (Name)_____**Date of Birth**___/___/___

Hereby authorize the request of medical information from other service providers

Eg. Pathology/X-ray/Specialists/

Signed_____**Date:**_____

Office use:

RECEPTION TO SIGN WHEN ABOVE COMPLETE AND PLACE IN SISTER'S TRAY _____

SISTER TO ADD RECALLS THEN PLACE IN SCANNING TRAY _____

(to be read in conjunction with the *Practice Privacy Policy*)

I, _____ have read and understand the information *insert patient name*

Contained in Ti Tree Family Doctors *Patient Privacy Information*, including:

- the types of personal information collected by the Practice, the reasons why it is necessary to collect it and the circumstances in which my personal information may be used or disclosed;
- that I may request access to my personal information, which may be granted in accordance with the Practice's *Access to Personal Information Policy*. I will be provided with a written reason if access is denied;
- that I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied;
- that my personal information will not be used for direct marketing or disclosed to overseas recipients;
- that I am not obliged to provide the Practice with my personal information, but withholding information may limit the Practice's ability to provide me with full service.
- that I have the right to lodge a compliant about the handling of my personal information if I am dissatisfied, which will be dealt with in accordance with the Practice's complaint handling procedure.

Signed _____
Patient or parent/guardian of patient

Date _____