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

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 ___________________________________