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**ABN: 68 833 254 679**

Suite 6, Ground Floor,

32 Florence St., Hornsby, 2077

Ph: 9476 2255 Fax: 9476 3355

**Patient Registration Form**

**We are committed to providing our patients with the highest standards of care. In order to do this, it is essential that your health records are kept up to date and accurate. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| Could you please assist us by completing the following: | | | |
| Title | € Dr € Mr € Mrs € Ms € Miss € Master (please tick) | | |
| First Name: | Middle Name: Surname: | | |
| Known As: | Date of Birth Sex (circle) Male/female/intersex/intermediate/transgender | | |
| Country of Birth: | Year of Arrival in Australia: Ethnicity: | | |
| Street Address: |  | | |
| Suburb: | State: Post Code: | | |
| Home: | Mobile No: | | |
| E-mail: |  | | |
| Medicare Number: | | Ref No: | Expiry: |
| € DVA Gold € DVA White (please Tick) | | No: | Expiry: |
| Pension Number | | No: | Expiry: |
| Health Care Card | | No: | Expiry |
| Next of Kin/Preferred Contact:  Relationship: | | Name:  Phone: | |
| Emergency Contact: | | Name:  Phone: | |
|  | |  | |

**Patient Background**

|  |
| --- |
| Do you identify as someone from a culturally and/or linguistic diverse background? |
| € No  € Yes (please elaborate) |
| To assist with health initiatives- are you of Aboriginal or Torres Strait Islander descent? |
| € No  € Yes- Aboriginal  € Yes- Torres Strait Islander  € Yes- Aboriginal & Torres Strait Islander |
| € Chronic Illness |
| Do you have any allergies or are you sensitive to any drugs or dressings?  € No € Yes (please specify name and reaction): |

**Children’s Immunisations**

|  |
| --- |
| If completing this form for a child, are their immunisations up to date? |
| € Yes  € No |

**Reminder Systems**

**Our practice provides our patients with preventative care and early case detections reminders via HOTDOC e.g. immunisations, annual health checks, skin checks and pap smears. It is a safe and encrypted mode of communication.**

|  |  |
| --- | --- |
| Do you wish to have any relevant health reminders sent to you? | |
| € Yes- by sms  € Yes- by E-mail | **€ No** |

**Florence St Family Practice Health Information Collection, Use and Disclosure**

**Consent Form (Please read this consent form carefully prior to signing.)**

**Introduction**

We are committed to protecting the privacy of patient information and to handling your personal information in a responsible manner in accordance with the Privacy Act 1988 (Cth), the Privacy Amendment (Enhancing Privacy Protection) Act 2012, the Australian Privacy Principles and relevant State and Territory privacy legislation (referred to as privacy legislation).

This general 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, and treat illnesses and medical conditions, ensuring we are proactive in your health care. Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed. The information we collect may be collected by a number of different methods examples include medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we need to record your consent or restrictions to this consent. By signing below, you (as a patient/parent/guardian) are consenting to the collection, use and disclosure of your personal information for the following purposes:

* Administrative purposes in the operation of our general practice.
* Billing purposes, including compliance with Medicare requirements.
* Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice.
* Accreditation and quality assurance activities to improve individual and community health care and practice management.
* For legal related disclosure as required by a court of law.
* For the purposes of research only where de-identified information is used.
* To allow medical students and staff to participate in medical training/teaching using only de-identified information.
* To comply with any legislative or regulatory requirements, e.g., notifiable diseases.
* For use when seeking treatment by other doctors in this practice
* We may also need correspond with you via SMS or your unencrypted email about your care. For example: in order to send you follow-up reminder/recall notices for treatment and preventative healthcare or to send you a referral or e-script. If you need more information about this, please ask reception for a copy of our “Patient e-mail Policy”

**Collection**

We collect information that is necessary and relevant to provide you with medical care and treatment, and manage our medical practice. This information may include your name, address, date of birth, gender, health information, family history, credit card and direct debit details and contact details. This information may be stored on our computer medical records system and/or in hand written medical records.

Wherever practicable we will only collect information from you personally. However, we may also need to collect information from other sources such as treating specialists, radiologists, pathologists, hospitals and other health care providers.

We collect information in various ways, such as over the phone or in writing, in person in our practice. This information may be collected by medical and non-medical staff.

In emergency situations we may also need to collect information from your relatives or friends.

We may be required by law to retain medical records for certain periods of time depending on your age at the time we provide services.

**Use and Disclosure**

We will treat your personal information as strictly private and confidential. We will only use or disclose it for purposes directly related to your care and treatment, or in ways that you would reasonably expect that we may use it for your ongoing care and treatment. For example, the disclosure of blood test results to your specialist or requests for x-rays.

There are circumstances where we may be permitted or required by law to disclose your personal information to third parties. For example, to Medicare, Police, insurers, solicitors, government regulatory bodies, tribunals, courts of law, hospitals, or debt collection agents. We may also from time to time provide statistical data to third parties for research purposes.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the information above and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for my personal information to be collected, used and disclosed as described above, **including contact via SMS to my mobile phone number or email**. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If not patient signing - your name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relationship to patient: (e.g. Mother, Father, guardian)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_