

## NEW PATIENT REGISTRATION FORM

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Male / Female (Please circle) Title: Mr/Mrs/Ms/Miss/Mstr Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Residential Address: \_\_\_\_\_ Suburb \_\_\_\_\_ Post Code \_\_\_\_\_

Postal Address (if different from residential) \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address (16+ only): \_\_\_\_\_ Do you allow SMS for reminders/recalls: Yes  No

Occupation: \_\_\_\_\_ Student: Yes  No

Medicare Card Number: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry: \_\_\_\_\_

Dept Vet Affairs Card No: \_\_\_\_\_ Expiry: \_\_\_\_/\_\_\_\_ Gold/White (please circle)

If White, conditions covered: \_\_\_\_\_

Pension / Health Care Card No: \_\_\_\_\_ Expiry: \_\_\_\_/\_\_\_\_ EHealth Registered: Yes / No

Do you identify as: Aboriginal  Torres Strait Islander  Neither:  Refugee

Cultural Background: \_\_\_\_\_ Languages Spoken: \_\_\_\_\_ Interpreter Required: Yes/No

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Mobile Ph: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

We'd love to know how you heard about us. Online  Website  Letterbox Drop  Facebook:

Shopping:  Chemist:  Email:  Family / Friends:  White Pages:  Yellow Pages

Google:  Health Engine:  Local Newspaper:  Other:  (please advise).....

How did you book this appointment? Online  In Person  Telephone

Your health is important to us; please tick if you would like more information on any of the following services:

Skin Check  Asthma Education  Quit Smoking  Immunisation/Vaccination

45 to 49 year Health Assessment  75 year + Health Assessment  Diabetes Education

PLEASE TURN OVER TO COMPLETE THIS FORM

**Office Staff Only**

Medicare Sighted – YES / NO      Photo ID Sighted – YES / NO      Staff Member Initials .....

## PATIENT INFORMATION CONSENT

We require your consent to collect personal information about you. Please read this information carefully and print your name and sign where indicated below. This information is used for the primary purpose of providing quality health care services for your health care needs. This practice has a strict policy on handling patient information. To ensure the security of personal information only authorised staff within the practice has access to this information. The information that you provide will only be used for:

- Administrative purposes
- Email purposes – Practice updates and newsletters
- Billing purposes, including compliance with Medicare Australia requirements
- Disclosure to others involved in your care, i.e. Referrals, case conferences, medical tests or results.
- DE identified data provided to external bodies for health improvement purposes.

In other situations we would not disclose your personal information without your consent.

### Privacy Policy:

Full copy available on request.

### Restricted Drug Policy:

Patients requesting prescriptions for drugs MUST adhere to the following guidelines: -

1. Be in a position to have documentary evidence justifying the prescription.
2. Produce further proof of identity in addition to your Medicare card.

All prescriptions for restricted drugs are verified with the following government agencies

1. Medicare Australia
2. Queensland Health Drugs of Dependence Unit.

We use Medisecure and all our scripts are barcoded.

Any children under the age of 16 years of age must be accompanied by a parent or guardian.

I have read this information above and fully understand the content. I consent to the handling of my information by Labrador Park Medical Centre for the purposes set above.

Patients Name: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

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

**Please note: Patients who fail to attend booked appointments, without notice (1hr), will be charged a \$10 fee for a short appointment, or \$20 for a long appointment.**

**No further appointments will be permitted until the outstanding fee is paid.**

We are pleased to be able to send seasonal information to keep you up to date with the practice and the services on offer. Please tick if you **do not want** to receive this information from the surgery by email or SMS