New Patient Registration & Consent

Bluff Point Medical Centre

PATIENT DETAILS						
Title		Date of Birth	___ / ___ / ______	Gender	Male / Female / Other	
Surname		Given Name/s				
Address (Res)		State		Post Code		
Address (Postal)		State		Post Code		
Home Ph		Work Ph		Mobile Ph		
Email (please use email unique to you, i.e. not work)						
Concession Card	Pension Card / Healthcare Card	Please supply card to staff prior to appointment				
Department of Veterans Affairs	Gold Card / White Card	Please supply card to staff prior to appointment				
Private Health Fund		Membership Number				
CULTURAL IDENTITY						
To assist with health initiatives – do you identify as Aboriginal and/or Torres Strait Islander?						
☐ No	☐ Yes – Aboriginal	☐ Yes – Torres Strait Islander	☐ Yes – Aboriginal and Torres Strait Islander			
Ethnic Background (i.e. Australian, British, Chinese, African etc.)						
Religion		Do you require an Interpreter Service?	☐ Yes ☐ No			
NEXT OF KIN CONTACT DETAILS						
Name		Relationship to you				
Home Phone		Mobile Phone				
EMERGENCY CONTACT DETAILS (ideally someone different to your Next of Kin)						
Name		Relationship to you				
Home Phone		Mobile Phone				
HEAD OF FAMILY (if patient <18 years of age)						
Name		Date of Birth	___ / ___ / ______			
TRANSFER OF MEDICAL RECORDS FROM YOUR PREVIOUS DOCTOR						
If you would like your notes or health summary sent to us, **please request a transfer form at the front desk**.						
OUR FEE STRUCTURE						

- We are a **private billing practice**, and all fees are required to be paid on the day, unless prior arrangements have been organised.
- Any service requested by you may incur an out-of-pocket fee.
- Please initial here that you have read and understood our fee structure. [ ]

Office Use Only: Type of Photo ID Observed____________________ - Initial: _______

DISCLOSURE OF INFORMATION TO A THIRD PARTY

A “third party” is someone that is **not legally allowed** to access or discuss anything to do with personal medical information without patient consent. Examples include a spouse, close friend of family member. Unless we gain patient/guardian permission w**e will not disclose or provide any information, verbal or written to a third party.**
By completing the table below, you (as a patient/parent/guardian) are consenting to the ongoing access of personal information by the stated third party, and only to the level of access indicated. **It is important for you to inform the practice or your doctor of any changes or exceptions to this access as soon as possible.**
Please **tick** which access you want to allow. Please **leave blank** if you do not want third party access to your records.

Full name of parties granted access	Relationship to patient	**Administrative Access:** Paying bills Booking appointments Collection of correspondence	**Health Access:** Medical and appointment history Results communication Ordering prescriptions

COMMUNICATION WITH YOU

<u>We will use all the contact details you have provided where necessary to assist you with your direct health care including:</u>

- Clinical communications (recalls for your tests results etc.)
- Preventative/clinical health reminders (i.e. blood tests, immunisations, CST reminders)
- Appointment reminders or changes

Preferred Contact Method

To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

My preferred contact method for all communication is:	☐ Phone	☐ Letter	☐ SMS	☐ Email
I wish to ***receive automatic SMS reminders for my appointments.***	☐ Yes		☐ No	

To the extent that the mobile number I have provided is utilised by more than one person, I understand and consent that all SMS and phone communications will be directed to that number.

Clinical Reminders

We will send you any reminders that you and your GP agree to. We prefer to send reminders via email or SMS, where appropriate, and this can be through the use of third-party service providers (who comply with the Privacy Act 1988). You have the ability to opt out from these services at any stage by following prompts in our communications, in your automated welcome messages or speak with one of our team.

I wish to receive my ***preventative/clinical health reminders*** *electronically by email or SMS as standard.*	☐ Yes	☐ No

Health Awareness Information

Health awareness information is carefully selected communication. Examples are: Updating you on changes **to practice opening times, influenza vaccination information, specific health topics** like diabetes awareness etc.

I wish to receive ***health awareness information*** *(as described above) and I hereby consent to the use of my personal and health information by Bluff Point Medical Centre to assess the types of health awareness communication it sends me and consent to receipt of such health awareness information.*	☐ Yes	☐ No

To be read in association with the "**Patient Consent to Collect, Use, Store and Share Information (2021.11 Version 1)**". By signing below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the stated purposes in this consent. You are free to withdraw, alter or restrict consent at any time by notifying this practice.

I, ______________________________ have read the information in this consent 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.

Patient name (please print): ____

Signature: ______________________________ **Date:** ______________________________

If not patient signing - your name (please print): ______________________________

Your relationship to patient (e.g. Mother, Father, Guardian): ______________________________