health plus.

Patient Registration Form

Admin Only:

Doctor:

☐ ID & MC/Cards Checked

☐ Data Entry ☐ Scanned

Patient Information

Title: Family Name: First Name: Preferred Name:

Date of Birth: Country of Birth: Language Spoken at Home:

Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ De-facto ☐ Divorced ☐ Widowed ☐ N/A

Are you Aboriginal or Torres Strait Islander? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Prefer not to answer

Physical Address: Suburb: State: Postcode:

Mobile Number: Home Number: Work Number:

Email Address:

Do you wish to receive SMS appointment reminders? ☐ Yes ☐ No

Do you wish to receive health related email correspondence? ☐ Yes ☐ No

At Health Plus General Practice (HPGP), we aim to provide high quality care to all our patients with a focus on preventable health services. As such, we may contact you when routine health checks and follow ups are due.

Patient Information

Medicare Number: Reference Number: Expiry Date:

DVA Card Number: Card Type: ☐ Gold ☐ White Expiry Date:

Government Issued Age Pension Card Number (PCC): Expiry Date:

Government Issued Health Care Card Number (HCC): Expiry Date:

☐ I do not have any of the above cards and am aware I will need to pay for my appointments at the time and date of service. I will be provided a receipt that I may present to my own private insurance to claim for reimbursement.

PLEASE CONTINUE TO NEXT PAGE ▶

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Contacts:

Emergency Contact Name: Relation to me: Number:

Next of Kin Name: Relation to me: Number:

- [ ] I/my child have custody or court orders in place.
- [ ] I wish to discuss custody arrangements and other contact details with my doctor to protect my privacy or the privacy of my child.

Consent:

By completing and signing this form to become a patient at HPGP, I agree to the following:

- I consent to the disclosure and use of my personal information by HPGP and any other health care providers and specialists involved both directly and indirectly in my ongoing care and medical treatment.
- I consent to receive written or verbal communication to the phone number and address I have provided on this form.
- I have read the HPGP Privacy Policy and Consent to Collect, Use and Disclose Personal Health Information. A copy of this is available at reception, and I understand I may request a digital copy to be emailed to me. After reading this information I understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but failure to do so may significantly compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I am aware of my right to request an amendment to information I believe is incorrect.
- I understand that if my information is to be used for any other purpose other than set out in the HPGP Privacy Policy and Consent to Collect, Use and Disclose Personal Information, my further consent will be obtained.
- I consent to HPGP handling my information for the purpose set out in the HPGP Privacy Policy and Consent to Collect, Use and Disclose Personal Information. I further acknowledge that this is subject to any limitations on access or disclosure of which I notify HPGP.

Printed Full Name: Signature: Date:

*Parent/Guardian if child is under 16