Patient Registration Form

Your Practitioner is committed to providing you with the best care. To do this it is essential that your health record is kept up to date and accurate. Thank you for your cooperation & please return your fully completed form to reception.

Title (please circle) Dr/ Mr/ Mrs/ Ms/ Miss/ Mstr/ Rev/ Sr

First Name: _____ **Surname**: _____ **DOB:** _____

Preferred Name: _____

Street Address: _____

Suburb: _____ **Postcode**: _____

Mobile No: _____ **Home Ph. No**. _____

Work Ph. No. _____ **Email Address**: _____

Occupation: _____

Postal Address (if different from above):

P O Box/Street: _____

Suburb: _____ **Postcode**: _____

Do you identify as someone from a culturally and/or linguistically diverse background?

□ **YES – please elaborate** _____

To assist with health initiatives, are you Aboriginal or Torres Strait Islander?

□**Aboriginal** □**Torres Strait Islander** □**Aboriginal & Torres Strait Islander** □**No**

Do you authorise the practice, on behalf of your doctor, to send you SMS appointment confirmations? YES / NO

The Practitioners at our practice provide their patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and Pap smears

Do you wish to have any relevant reminders sent to you?

□ **Yes – via mail** ***OR*** □ **Yes – SMS to this ph no:** _____ □ **No**

Please present to Staff if relevant:

Medicare Card # _____ **Ref#** _____ **Expiry:** _____

DVA # _____

Health Care Card # _____ **Ref#** _____ **Expiry:** _____

Pension Card # _____ **Ref#** _____ **Expiry:** _____

Next of Kin:

First Name: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Emergency Contact:

First Name: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Do you have any previous illnesses or medical conditions that your doctor needs to be aware of (tick below)?

□ High blood pressure □ Angina □ Diabetes

□ Bleeding tendency □ Stomach Ulcer □ Asthma

□ Hepatitis □ Skin cancer surgery □ Varicose Veins

□ Deep vein thrombosis □ Currently pregnant □ HIV

□ Heart valve surgery □ Other – provide relevant details below

Do you have any allergies or are you sensitive to drugs or dressings?

□ **Yes (if yes, please list below)** □ **No**

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Your Health Information

In accordance our obligations under the *Privacy Act 1988* (Cth) and the Australian Privacy Principles , we are required to provide you with details as to how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Our practice operates in accordance with our obligations under the Privacy Act and its Privacy Policy. A copy of our Privacy Policy is available free of charge from reception or on our website.

Your independent practitioner uses the information you provide to manage your health care, which may include using and/or disclosing the information for the following purposes (including instructing us to use and/or disclose the information for the following purposes on your doctor's behalf):

1. Recording and storing your personal and health information as part of an individual computerised and/or hard copy medical record.
2. Sending specimens obtained from you to the necessary pathology providers for analysis (which may incur an out-of-pocket expense, which will be issued as a separate invoice by the relevant pathology provider).
3. Scheduling your appointment with your doctor.
4. Issuing reminders for specific health checks you may require, if any, as part of your consultation with your doctor and/or nurse.
5. Providing you with health information updates, general medical updates and providing your personal and health information to the relevant state and/or national recall reminder registers.
6. Using your personal and health information to undertake administrative tasks involved in the running of the practice (including, but not limited to, Accreditation and Quality Assurance activities conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers), and for your doctor, billing tasks, accounting procedures and the collection of professional fees, which includes compliance with Medicare, Health Insurance Commission and other relevant Government agency requirements.
7. For legal related disclosures as required by a court or other regulatory body.
8. For the purposes of research where de-identified information is used.
9. To allow medical students and staff to participate in medical training/teaching using only de-identified information.
10. For disease notification as required by law.
11. For use when seeking treatment by other doctors practicing from this practice or other authorized individuals involved in your medical care and treatment, both directly and indirectly.

- By signing below, you (as a patient/guardian) are consenting that on obtaining your personal health information it may be used or disclosed by the practice on your doctor's behalf for the above 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 sign this form as confirmation that you have read and understood the appointment and fee information and consent to the use of your personal and health information as stated above.
- If you have any questions regarding the management of your personal health information or need to arrange access to your records, please ask reception or your doctor, as appropriate.
- You are not obliged to provide any information requested, but that your failure to do so may compromise the quality of care provided to you by your doctor.
- You understand your rights to access both your personal and health information held by this practice and your doctor, except in circumstances where access is legitimately withheld. If your personal and health information is to be used for any other purpose, other than what is set out above, your further consent will be obtained.
- You understand it is your responsibility to inform this practice as soon as practicable of any changes to your personal and health information. If any information held about you is inaccurate, you may request to have this altered accordingly.

12. AI "Artificial Intelligence" technology will be used for transcription of consultation notes.

If you do not wish for this to occur, please advise reception or your Practitioner.

I, _____, give my permission for my personal health information to be collected, used and disclosed for the purposes set out above. I understand only I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____ DOB: ___ / ___ / ___

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____

Privacy Collection Statement

This practice collects your personal information for purposes related to (or in the case of sensitive information, directly related to) our functions or activities, including facilitating the delivery of health services to you from your health practitioner, informing you of services which may be relevant to you and to communicate with you on behalf of your health practitioner. We may not be able to facilitate the delivery of health services from your health practitioner to you if you do not provide this information. Your personal information may be disclosed to our related bodies corporate, health practitioner, and third-party services providers. Your personal information is kept private and secure, as required by federal and state privacy laws.

Please refer to our Privacy Policy for full details of how we handle your personal information, including how you may access and seek correction of your personal information, complain about a privacy breach, and how we will deal with that complaint.

REQUEST FOR COPY OF MEDICAL RECORD

I hereby authorize Mallee Border Health Centre to obtain a copy of a medical summary and relevant medical information (please tick)

Yes ☐ ***If Yes, please complete the medical records authority form (page 4)*** No ☐

By signing this consent form, I acknowledge that I have read, understood and agree to all the Terms and Conditions set out in the 'Mallee Border Health Centre – Patient Agreement'

Signature …….. Date: ……/……/……..

PO Box 147, Pinnaroo S.A. 5304
Ph: 0885 778 065 Fx: 0885 778 681
hello@malleeborderhealth.com.au
www.malleeborderhealth.com.au

Medical Records Transfer Authority

Date: ……

Medical Centre information coming from:

Dear Dr/Medical Centre: ……

Address: ……

Phone Number: …… Fax Number: …….

(Please do not send disk-usb acceptable with RTF or Word Format)

I agree to my records being transferred by: Email ☐ Fax ☐ Post ☐

The below is a patient now attending this practice and records are required for:

Names	DOB	Signatures
…….	……	……
…….	……	……

Would you kindly forward a copy of:

- All clinical records including an accurate Health Summary with relevant correspondence and results.

  Please write dates below if any of the following have been conducted within the last 2 years

  "GP Management/TCA and Health Assessment's"

GP Management Plan	Date ……	GP Management Plan Review	Date ……
GP Mental Health Plan	Date ……	GP Mental Health Plan Review	Date ……
Team Care Arrangement	Date ……	Team Care Arrangement Review	Date ……
Mental Health Plan	Date ……	Mental Health Plan Review	Date ……
Health Assessment	Date ……		

Please forward below records:

Complete Patient Record/Summary ☐

Physiotherapy Records ONLY ☐

Speech Pathology Records ONLY ☐

Send to:

Mallee Border Health Centre

PO Box 147, Pinnaroo SA 5304

Ph: 08 85778065, Fax 08 85778681, Email: hello@malleeborderhealth.com.au