Corfield DOCTORS SURGERY

NEW PATIENT REGISTRATION FORM

Please complete **all** parts of the form clearly

TITLE: ***please circle*** MR MRS MS MISS MAST

SURNAME: _____

FIRST NAME/S: _____

MIDDLE NAME: _____

PREFFERED NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

SUBURB: _____

POST CODE: _____

HOME PHONE: _____

MOBILE PHONE: _____

ETHNICITY/ COUNTRY OF ORIGIN: ***please tick***

☐ AUSTRALIAN

☐ ABORIGINAL

☐ OTHER (please specify) _____

☐ TORRES STRAIT ISLANDER

OCCUPATION: _____

MEDICARE AND CONCESSION CARD

CARD # ☐☐☐☐ ☐☐☐☐☐☐

REF # (the number appearing before your name on the card) ☐

EXPIRY DATE _____/_____

CONCESSION CARD HOLDERS

CARD NUMBER _____

EXPIRY DATE _____/_____/_____

☐ PENSIONER CONCESSION

☐ HEALTH CARE CARD

☐ SENIORS HEALTH CARD

Please tick

DVA CARD HOLDERS

CARD NUMBER _____

☐ GOLD

☐ WHITE

Please tick

NEXT OF KIN

FULL NAME: _____

RELATIONSHIP: _____

CONTACT NUMBER: _____

ADDRESS: _____

SUBURB: _____

POST CODE: _____

EMERGENCY CONTACT (different to above)

FULL NAME: _____

RELATIONSHIP: _____

CONTACT NUMBER: _____

ADDRESS: _____

SUBURB: _____

POST CODE: _____

PTO →

CONSENT DECLARATION (Please read and tick the boxes)

☐ I declare that I have answered the above questions correctly and to the best of my knowledge.

I understand that CORFIELD DOCTORS SURGERY complies with the privacy act (1998) and are committed to protecting my personal health information.

☐ I understand that I have the right to request access to my information except where access would be denied, and that CORFIELD DOCTORS SURGERY makes every effort to manage my information in accordance with the national privacy principals and keeps my records up to date.
I understand I may withdraw my consent for CORFIELD DOCTORS SURGERY to use and disclose my personal information following a discussion with the doctor (except when legal obligations must be met).

☐ I consent to CORFIELD DOCTORS SURGERY collecting, using, storing and disposing of my personal information and releasing relevant information to other Health Professionals for the purpose of quality medical care.

☐ I consent to inclusion on the CORFIELD DOCTORS SURGERY recall reminder system. I accept that I may receive correspondence from the practice by either phone call, text message or mail, for follow up visits that have been requested by the doctor, appointment reminders, medical updates and health information from the practice.

☐ I understand that all accounts must be paid at the time of consultation and that I am responsible for payment of any children under the age of 16, without a valid Medicare card, if I am their parent or guardian.

☐ I have received the CORFIELD DOCTORS SURGERY information leaflet.

☐ I acknowledge that CORFIELD DOCTORS SURGERY has a late or no-cancellation fee.

☐ I acknowledge that CORFIELD DOCTORS SURGERY is a bulk-billed practice, however certain procedures are not covered by Medicare and will incur a small fee.

EMAIL: _____

PATIENT OR PARENT/
GUARDIAN SIGNATURE: _____ DATE: _____

HOW DID YOU HEAR ABOUT US?

_____