BANK PLACE
MEDICAL CENTRE

1 Hopetoun Road,
Drouin Vic, 3818
Ph: 03 5625 3000
Fax: 03 5625 4108

Patient Registration Form *Please complete the following details*:

Family Name (Mr/Mrs/Ms/Miss/Master) .....

Given Name.....Preferred Name .....

Date of Birth ...../...../.....(dd/mm/yy)

Marital Status:.....

Address: (Number)..... (Street).....

(Suburb)..... (Postcode).....

Telephone: (home).....(work)..... (mobile).....

Email address:_____@_____

Employment/Occupation.....

Aboriginal ( ) Torres Strait Islander ( ) Nationality .....

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Patient Reference No ___ Expiry Date:___ ___/___ ___ ___ ___

Person responsible for paying account:.....

Are you covered by:	**Entitlement Number**	**Expiry Date**
Pensioner Health Benefits Card	_____	___/___/_____
Health Care Card	_____	___/___/_____
Dept of Veterans Affairs		
☐ Gold	_____	___/___/_____
☐ White	_____	___/___/_____

*Conditions:*_____

Emergency Contact: Name:.....

Phone: (home) .....(work)..... (mobile).....

Relationship to patient:.....

My Health Record *(see attached for more information)*

Are you registered for My Health Record Yes / No
If **NO** would you like BPMC to register you now Yes / No
If **Yes** please advise our receptionist when handing back this form

Patient Signature.....

Please turn over for consent form →

BANK PLACE
MEDICAL CENTRE

Health Information Collection and Use Consent Form

Bank Place Medical Centre needs to collect information about you for the primary purpose of providing a quality service to you. In order to thoroughly assess, diagnose and provide therapy, we need to collect some personal information from you. If you do not provide this information; we may be unable to treat you.

This information will also be used for:
a. The administrative purpose of running the practice;
b. Billing either directly or through an insurer or compensation agency;
c. Use within the practice if discussing or passing your case to another practitioner within the practice for your ongoing management;
d. Disclosure of information to your doctors, other health professionals or to teachers to facilitate communication and best possible care for you; and
e. In the case of insurance or compensation claim it may be necessary to disclose and/or collect information that concerns your return to work to an insurer or your employer.
We do not disclose your personal information to overseas recipients.

Bank Place Medical Centre has a Privacy Policy that is available on request and is available in the waiting area.

That policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your management. These may include your doctor, teachers, specialists, insurers, solicitors or employers.

I, _____ have read the above information and understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my assessment and therapy progress.

I am aware that I can access my personal and treatment information on request and if necessary, correct information that I believe to be inaccurate.

I understand that if, in exceptional circumstances, access is denied for legitimate purposes, that the reasons for this and possible remedies will be made available to me.

I have been provided with or have been given an opportunity to obtain a copy of Bank Place Medical Centre privacy policy.

Patient's signature_____ Date_____/_____/_____

Signed as Guardian for child_____ _____Name (printed) _____