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*:

Please circle: (Mr / Mrs / Ms / Miss / Master / Other) .....

Family Name .....

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

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

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

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

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

Consent to SMS Reminders : Yes / No

Email address:_____@_____

Employment/Occupation.....

Australian ( ) Aboriginal ( ) Torres Strait Islander ( )

Other 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:.....

Patient Signature.....

Please turn over for consent form ➡

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Health Information Collection, Use and Disclosure Consent Form

Bank Place Medical Centre needs to collect information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details to thoroughly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed; we will record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.

The information we collect may be collected by a number of different methods, and may include, but not limited to: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

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 following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

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 complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

Consent

I, _____ have read the information above 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.

I, _____ give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient name: (please print) _____

Signature: _____ Date: _____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian) _____