Peppertree GP

Patient Registration Form

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

Pronoun (please tick) She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐

First & middle Name: _____ **Surname**: _____

Preferred Name: _____

DOB: _____

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**: _____

If we need to contact you, what is your preferred method of contact?

☐ **Home Phone** ☐ **Mobile Phone** ☐ **Email** ☐ **Mail**

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

□ **YES** – please elaborate _____

To assist with health initiatives, do you identify as Aboriginal or Torres Strait Islander?

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

Do you authorise the practice to send you SMS appointment confirmations? YES / NO

Our practice provides our patients with preventive care and early case detection reminders e.g. newsletters, immunisation recalls, annual health checks, skin checks and Pap smears

Do you wish to have any relevant correspondence sent to you via SMS or email?

☐**Yes** ☐**No**

To provide you with the highest level of care, Peppertree GP will use Health Professional Online Services to check your eligibility for Medicare Item Numbers. Do you consent to this?

☐ **Yes** ☐ **No**

Please present to staff if relevant:

Medicare Card no: _____ IRN:_____ Expiry:_____

DVA no:_____ Card type: _____ Expiry: _____

Health Care card no:_____ Expiry: _____

Pension Card no:_____ Expiry: _____

Private Health Fund Ins: _____ PH Ins No: _____ Expiry: _____

Next of Kin:

First Name: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Emergency Contact:

First Name: _____ **Surname**: _____

Phone No: _____ **Relationship**: _____

Do you have any previous illness or medical condition we need 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**

_____

_____

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the Australian Privacy Principles , we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health 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 personal health information is used or disclosed.

The information we collected may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance 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/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- 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.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

Patient (please print): _____

Signature: _____ Date: _____

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

WE ARE A MIXED BILLING PRACTICE.

Bulk billing applies only to those:

- 65 years and older on a valid pension card
- 12 years and under

(excluding procedures / skin checks etc)

PAYMENT IS TO BE MADE AT THE TIME OF THE CONSULTATION.

EFTPOS FACILITIES & MEDICARE CLAIMING IS AVAILABLE ON SITE.

Peppertree GP