Carrier Street Clinic Registration and Consent Form

We are committed to providing our clients with the best care, to do this it is essential that your health records are up to date and accurate. Could you please assist us by completing the following:

Title	**Mr**	**Mrs**	**Ms**	**Miss**	**Mst**
Surname				
First Name				
Date of Birth				
Street Address				
Suburb and Post Code				
Home Phone				
Work Phone				
Mobile Phone				
Medicare Card Number			**Reference Number :**	
Health Care/Pension Card				
DVA Gold / White (Please circle)			**Expiry Date**	
Workers Compensation- Insurance Company & Claim Number			**Case Manager**	
Next of Kin	(Name and Phone number)			
Emergency Contact	(Name and Phone number of the person we can contact if needed)			
Previous General Practitioner	Name: Address:			
Country Of Birth (Ethnicity)				
Occupation/Employer				
Any known Allergies				
Are you a smoker (yes/no)				

******Please bring all you current medications with you to your first consultation with the doctor*****

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds –Do you identify as someone from a culturally and/or linguistic diverse background? Are you Aboriginal or Torres Strait Islander?

☐ Yes - Please elaborate……☐ No

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Your **Personal Health Information and your Health Record** may be collected, used and disclosed for the following reasons:

For communicating relevant information with other treating general practitioners

For follow up reminder / recall notices
For National/State or territory registers
For State/Territory reminder systems
Accounting / Medicare / Health Insurance procedures
Quality Assurance activities such as accreditation
For disease notification as required by law (e.g. infectious diseases)
For use by all general practitioners in this group practice when consulting with you
For legal related disclosure as required by a court of law (e.g. subpoena, court order, suspected child abuse)
For research purposes (de-identified, meaning you are not able to be identified from the information given)

If you have any concerns or wish to restrict access to your personal health information please discuss these with your general practitioner or receptionist. This practice adheres to National Privacy Principles (www.privacy.gov.au) and has a written policy, which is available to all clients for inspection.

Our practice may provide clients with a reminder if you haven't attended consultations as planned with your general practitioner.

Do you consent to have any relevant reminders sent to you?
☐ Yes- by mail ☐ Yes- by SMS to the above mobile phone ☐No

Do you have an implanted cardiac pacemaker?
☐ Yes ☐No

I acknowledge as a new patient I would be expected to pay my account at my first consultation, and continue with a good payment history, otherwise I will not be accepted as a patient of the clinic.
☐ Yes ☐No

Would you like assistance in Registering for 'MY HEALTH RECORD'?

☐ Yes ☐No

Please present concession card and Medicare cards to reception when returning this form

Signature_____ **Date** _____