

‘DOCTORS OF IVANHOE’

NEW PATIENT REGISTRATION FORM

21/03/2019

**PAYMENT BY ALL PATIENTS IS REQUIRED AT TIME OF CONSULTATION*

**PATIENTS WITHOUT A MEDICARE CARD WILL NEED TO PRODUCE PHOTO ID*

MR MRS MS	FIRST NAME:	MIDDLE NAME:	Date of Birth:
	SURNAME:		Gender Male / Female <i>or discuss with your doctor</i>
Address:		Phone: (H)	
Suburb:		(W)	
		(M)	
Email Address:			
Medicare Number:	IRN:	Expiry date:	DVA Number: Expiry Date:
Pension / HCC Card Number:	Expiry Date:		Gold Card Y/N
Commonwealth Seniors Card: Y / N		White Card: Y (reason)	
Next of Kin:	Relationship:		Emergency contact:
Ph: (H) (M)			Same as Next of kin: <input type="checkbox"/>
		Ph: (H) (M)	
Occupation:	Country of Birth:	Year of arrival in Australia:	Do you require an interpreter? Y / N
	Ethnicity:		
Marital Status:	Language Spoken:	Do you identify as Aboriginal &/or Torres Strait Islander? Y / N	
	Preferred Language:		

Are you responsible for paying the account? YES / NO (*Example parent of a child or Work Place*)
If NO please include Payer details in boxes below ↓

Name of person / company responsible for account:	Date of birth:
Address:	Medicare No:
Ph: (H) (M)	IRN: Exp Date:

PATIENT HEALTH INFORMATION

Are you a smoker? Y / N Do you consume alcohol? Date of last Pap Smear?	Immunisation history?	Allergies:
Current Active Problems?	Past Medical / Surgical History?	
Current Medications?	Family History?	

PATIENTS PLEASE READ AND SIGN - PATIENT CONSENT:

By registering with our Practice you give consent for our doctors and staff to access and use your personal information so they can provide you with the best possible healthcare. Only staff who need to see your information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this. We use your information for directly related business activities, such as financial claims and payments, practice audits and accreditation, and business processes (eg staff training). For further information regarding our Privacy Policy please refer to our website www.dr131.com.au or ask reception staff for a copy.

I consent to the use of my mobile number so that I may be sent an SMS for my Recalls and Reminders and Health Alerts. I will advise Reception or my doctor if I do not want my mobile used for this purpose.

Patient to sign here:

Date: