Patient Registration Form

This form may downloaded, filled electronically and emailed to admin@mayfieldmedicalconnection.com.au
Please use the subject "New Patient Form"
OR print the form and return it prior to your first phone or on site appointment. If attending our site, with a printed form, **please arrive 15 minutes early** so your medical record may be established prior to seeing your GP.
Email is not considered a secure messaging platform. If this concerns you, please feel free to fax your form to 02 4968 1912 or phone our team on 02 4968 2157 to provide your information personally.

A Personal Details

Title □ Mr □ Ms □ Mrs □ Mast □ Miss □ Dr ■ Other

Given Name | Middle Name | Family Name

Preferred Name | Date of Birth | Gender: □ Male □ Female ■ Other

Medicare Number | Ref no. | Expiry date | Occupation

Address

Home Phone | Mobile | For patients over 16 years of age, this is my mobile number: Yes ○ No ○

Private Health Insurer/Fund (if Applicable)
Name of Fund: Insurance Number:

Email

Allergies (include reaction + severity)

B Ethnicity and Culture

Do you wish to identify yourself as: ○ Aboriginal ○ Torres Strait Islander ○ Both ○ Neither
If yes, are you registered for Closing the Gap (CTG)? □ YES ■ NO

Country of birth | Ethnicity | Spoken Language

Do you require an interpreter? (ph. 131 450) □ YES

C Concessions

Pension number | HCC Number | Expiry Date | DVA Number

D Emergency Contact and Next of Kin (please provide two names)

Emergency Contact
Name | Relationship | Phone

Next of Kin
Alternate Name | Relationship | Phone

E Head of Family – ONLY FILL FOR PATIENTS 16 AN UNDER

For billing and Medicare purposes patients 16 and under require a Head of Family to be registered with the practice. Please include your details below:

Title □ Mr □ Ms □ Mrs □ Mast □ Miss □ Dr ■ Other

Given Name | Last Name | Date of Birth

Address

Medicare Number | Ref no. | Expiry date

PLEASE CONTINUE

F Non-Attendance/Cancellation Fee Policy

As a Patient of Mayfield Medical Connection, I acknowledge and accept the policy of at least 2 hours' notice for cancellations. Failure to do so may result in a non-attendance/cancellation fee of $40

Initials: _____

G Health Information Collection and Use Consent – please read carefully before you sign

Why and how we collect and use your personal information

As a patient of our medical practice, we require your personal details and a full medical history in order to properly assess, diagnose, treat and be proactive in your health care. We aim to protect the privacy and securely store your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

This practice will use and/or disclose your information for the following:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors, specialists, nurses and allied health professionals outside this medical practice. This may occur though referral to other medical providers or for medical tests, as well as in the reports or results returned to us following referrals.
- Disclosure to other medical professionals in the practice including locums attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that may identify you be required you will be informed and given the opportunity to opt out of any involvement.
- To your employer in the case of employment or pre-employment health checks and to their insurance providers in the case of workers' compensation claims.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For follow-up recalls and/or reminder letters for treatment and preventative health. This may be done by mail, phone or SMS.

You can decline to have your health information used in all or some of the ways outlined above but it may affect our ability to manage your health care to the highest standards.

SIGNATURE

□ **I have read and I understand this form.**

□ **By signing below, I consent to the collection and use of my information by the practice for the purposes set out above, subject to any limitations on access or disclosure of which I will notify this practice.**

Name	Signature	Date

□ I am signing on behalf of my child/dependent
Name of child/dependent

OR

□ **I am unsure and would like to discuss this further with someone from the practice before I sign.**

How did you find us? ○ **Family/friends** ○ **Our website** ○ **Internet** ○ **Flyer** ○ **Other**

This form may downloaded, filled electronically and emailed to admin@mayfieldmedicalconnection.com.au
Please use the subject "New Patient Form"
OR print the form and return it prior to your first phone or on site appointment. If attending our site, with a printed form, **please arrive 15 minutes early** so your medical record may be established prior to seeing your GP.
Email is not considered a secure messaging platform. If this concerns you, please feel free to fax your form to 02 4968 1912 or phone our team on 02 4968 2157 to provide your information personally.