

Patient Registration Form



This form may be downloaded, filled electronically and emailed to admin@mayfieldmedicalconnection.com.au **Please use the subject "New Patient Form"** OR print the form and ensure we receive it at least 1 business day before your first phone or on site appointment 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. Please phone our team on 02 4968 2157 if you need assistance. The final page explains the issues with email and provides the option to consent to the convenience of ongoing email communication with us.

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 AND 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 which must be paid before another appointment can be booked. **Initial appointments with Dr Jane Taylor must be canceled with at least one business day's notice given by phone and pre-paid on booking. Failure to attend will result in forfeiting the entire fee.** Ongoing appointments with Dr Taylor that are not attended or canceled by phone with a business day's notice will incur a fee equal to the cost of the appointment. Patients with outstanding fees are not able to book an appointment. Late attendance is considered to be a non-attendance.

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 through 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 may decline to have your health information used in all or some of the ways outlined above but it will 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

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Information and Consent for Correspondence by Email

Mayfield Medical Connection takes your privacy and confidentiality seriously and has obligations to take reasonable steps to protect your health information.

Despite our taking every care, email communication may put your privacy and confidentiality at risk. We therefore inform you that we cannot guarantee that emails with you are encrypted or that they won't be intercepted or forwarded inadvertently to the incorrect addressee.

Therefore, we are advising you that Mayfield Medical Connection cannot ensure the information in emails and/or attachments are kept private once they have been sent to you by email.

We will, at all times take every care to avoid breeches of your privacy.

Email correspondence remains very convenient. **If you accept the risks outlined above, please fill in this form and return it by email to admin@mayfieldmedicalconnection.com.au.**

By adding my name and identity details to this form I state that:

"I consent to email communication and accept the potential privacy risks as outlined to me by Mayfield Medical Connection."

Full Name:

Address:

D.O.B.:

When your email with your consent and identity details is received and read we will be able to correspond with you by email.

At times we may resend you this form prior to releasing your information by email as an extra precaution; by using the 'reply' option we can ensure the information is sent directly to you.

If you have any questions, please don't hesitate to call us.