St. George Mermaid Broadbeach MEDICAL CENTRE

OFFICE USE

**ID Verification**

Medicare ☐ Photo ID ☐

Staff Member Initial: .....

# NEW PATIENT REGISTRATION FORM

| | |
|---|---|
| Title | Mr / Mrs / Ms / Miss / Mst / Dr / Prof (please circle) |
| Gender Identity | Male / Female / Gender Diverse / Transgender / Different Identity (please circle) |
| Surname (as stated on Medicare Card): | |
| Given Names: | Preferred Name: |
| Date of Birth | |
| Do you self-identify as: | ☐ No ☐Aboriginal ☐Torres Strait Islander ☐ Both Aboriginal & TSI |
| Ethnicity / Ancestry | |
| Is English your first language? | ☐ Yes ☐ No *If no*, do you require an interpreter? ☐ Yes ☐ No *If yes*, what language? |
| Relationship Status: | ☐Married ☐ Single ☐ Defacto ☐Widowed ☐ Divorced ☐ Separated |
| Address: | |
| Suburb: | State: Postcode: |
| Phone: | Mobile: Home: |
| Consent to receive: | SMS messages for test recalls or reminders ☐ Yes ☐ No |
| Email* | |
| Occupation: | |
| Medicare No: | Ref (# in front of name): Exp: |
| Centerlink Card *(for Medicare billing purposes)*: | Pension No: Health Care No:<br>Senior's Health Care No: Exp: |
| Veteran Affairs No: | Card Colour: Exp: |
| If BUPA Overseas Student or Visitor: | Patient ID (# in front of name): Card No: |
| Next of Kin: | Name:<br>Phone: Relationship: |
| Emergency Contact: | As above ☐ or Name:<br>Phone: Relationship: |
| Can we leave a message regarding your appointment on your voicemail? ☐ Yes ☐ No | |
| Can we leave a message regarding your appointment with another member of your family? ☐ Yes ☐ No | |

**For medical correspondence purposes only; not marketing*

**Please be advised that St George on Mermaid Medica Centre Doctors DO NOT prescribe S8 medication on the first consult**

St. George Mermaid Broadbeach MEDICAL CENTRE

OFFICE USE

**ID Verification**

Medicare ☐ Photo ID ☐

Staff Member Initial: .....

# PATIENT CONSENT FORM

St.George on Mermaid Beach Medical Centre requires your consent to collect personal information about you for the primary purpose of providing quality healthcare. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise you on all your health care needs. Please read this consent form carefully.

> **I give consent** for Doctors/Staff to disclose my results and any relevant information that may be needed by another party eg: Specialist or Hospital, for the sole purpose of quality and continuity of care

> **I give consent** for Doctors/Staff to contact Medicare or any other organisation on my behalf for the collection of information that may be necessary for the sole purpose of quality and continuity of care.

> **I acknowledge** that after a consultation with my doctor, if there is an agreed management plan or recommended referral or test, then it is my responsibility to follow-up on these instructions.

> **I acknowledge** that I am responsible for arranging follow-up appointments with my doctor pursuant to any tests to discuss their results. I will not assume that the results are normal if I do not hear from my doctor. If I have any persistent or worsening symptoms, it is my responsibility to make a follow-up appointment.

> **I acknowledge** that it is my sole responsibility, and not that of the practice, to follow-up on health reminders sent by the practice.

> **I understand** that St George on Mermaid Beach Medical Centre has an agreement with Health Engine for SMS appointment reminders, as well as recall and health reminders.

> **I understand** that I am free to withdraw my consent at any time by verbal or written consent.

*St George on Mermaid Beach Medical Centre participates in quality improvement activities that require us to share **de-identifiable patient information** with third parties who work with our practice for business purposes, such as accreditation agencies and information technology providers – these third parties are required to comply with APPs and our privacy policy. **De-identifiable patient information cannot be traced back to the individual.***

**Do you give your consent? ☐ Yes ☐ No**

Name of Patient: _____

Signature of Patient: _____

Name and Signature of Parent/Guardian (if under 18): _____

Date: _____

**Please be advised that St George on Mermaid Medica Centre Doctors DO NOT prescribe S8 medication on the first consult**