hackhammedical centre

NEW PATIENT REGISTRATION FORM

Title (Please tick √) ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr Other ……	
First Name:	Middle Name:
Surname Name:	Known as:
Date of Birth	Country of Birth
Ethnicity – Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither	

Medicare Card No:	Ref No (this is the number you are on the card)	Expiry
☐Pension ☐Healthcare Card ☐DVA Number(Veteran Affairs) ☐No Concessions (Please tick which applies) Number on Card _____ Expiry _____		
Private Health / Hospital Cover (please tick)	☐Top ☐ Intermediate ☐Basic	
Claim Number	Workcover……Third Party……	

Residential Address	
Postal Address	
Home Phone No	Work Phone No
Mobile No.	Email Address
Occupation	
Marital Status (Please tick √) ☐Single ☐ Married ☐ Widowed ☐ Divorced ☐ De facto ☐ Separated	

Next of Kin / Emergency Contact Details		
Full Name:	Phone No	Relationship to you (i.e mother)

(Please tick)

Do you provide permission for the practice to leave a brief voice message on your phone ☐ YES ☐ NO

Do you give permission for the practice to send SMS notifications & reminders to your phone ☐ YES ☐ NO

Do you give permission for the practice to send letters for reminders & recalls ☐ YES ☐ NO

Please sign below

Name…… Signature ……Date……

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At Hackham Medical Centre we aim to provide you with the best possible care. We appreciate your co-operation and understand that information provided to us is highly personal and needs special care and protection. The Practice is committed to protecting your privacy in accordance with the national privacy principles (NPP). This obligation rests not only with the Doctors, but all members of staff who have access to this information – all of whom have signed confidentiality agreements.

COLLECTION OF INFORMATION

Staff members will record the following information on your file;

- Full name, date of birth, address and phone numbers – to allow correct identification of files, appointments and questions, to enable us to contact you when necessary.
- Medicare Number / Health Fund Details – necessary for account purposes.
- Pensioner, Veterans Affair or Healthcare Card details
- Medical details – Allergies, past history and medications.
- Referring Doctor's name and address – to enable us to communicate with your referring Doctor, and for you to obtain your Medicare rebate.

If you are unable to provide us with the above information we would have genuine concerns that we could not offer you the best standard care.

STORAGE AND DISPOSAL OF INFORMATION

X-rays or paper files stored in a central medical records area. Only authorised personnel may access these files. Information is stored on our computer system and which can only be accessed using a secure password. Any obsolete information is destroyed with your identity protected.

DISCLOSURE INFORMATION

Referring Doctors send letters to us which are scanned into your computer notes and then shredded. Your information may be released to other health providers if deemed to be in your best interest. Occasionally we are obligated by law to release details retaining to statutory requirements or public health matters – this information is kept strictly confidential.

In all other circumstances your written consent is required before we disclose information to a third party.

SIGNED CONSENT

I consent to the handling of my information by this practice for the purposes and in the manner set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signature……..Date……..

Name of Minor (if signing for a minor)…… ……

If you wish to discuss any matters related to your personal information or medical records, please do not hesitate to let our staff know so that appropriate arrangements can be made.

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RECALLS AND REMINDERS – PATIENT INFORMATION

Patients are ultimately responsible for their own health – and we encourage you to be actively involved in your own health care.

To help provide preventive care for you, we use a 'Recall and Reminder' system to ensure that important health checks are not forgotten, and performed on time. If you agree to be on this system, you will be reminded when it is time to visits your doctor for a check-up – or as follow up to health risks that have previously been found. The reminder system will include check-ups to help the prevention or early detection of certain conditions such as diabetes, high blood pressure, high cholesterol and forms of cancer – eg cervical, breast and prostate cancer, and immunisation follow ups, etc.

In some cases reminders may be sent from other places as part of the National Recall or Reminder System – eg the government pap smear register.

We will use information from your health record to check if and when these check-ups are due. Our doctors follow the guidelines for preventative care as outlined in the Royal Australian College of General Practitioners Guidelines for Preventative Activities in General Practice.

The new Privacy Laws require that we obtain consent to send you these reminders. You may discuss with your doctor the possible reminders you may need, and a note will be put in your record if you do not consent to be included in the Recall and Reminder System.

By allowing us to send a reminder letter, ring or text you, for these reminders (if you need one), you will help us detect serious conditions early, or to monitor known conditions. This can significantly improve the long term outcome for you. When you have had any tests we ask that you visit your doctor a few days later for your follow up of results. We may not always be able to reach you, especially if you have moved or your contact information has not been updated.

Please discuss with your doctor any concerns you may have, or if you need clarification on anything to do with the above information – and consent, if you wish to be on our recall and reminder system.

Thank you

CONSENT (Please Circle) **Yes** **/** **No**

Signature …… **Date ……**

If signing for a minor;

Name of Minor …….. Relation to Patient…….

MISSED APPOINTMENTS:

We understand that occasionally a patient will be unable to make a scheduled appointment due to unforeseen circumstances. If such unforeseen circumstances arise please contact the Practice at least 4 hours prior to your appointment time to cancel or re-schedule your appointment. This will then enable the practice to allocate the cancelled appointment to another patient.

If you fail to give the required cancellation notice or do not attend the appointment a non-attendance fee of will be incurred. This will require payment prior to making another appointment. This fee is non-claimable from Medicare.