Patient Registration & Information Form

We are committed to providing our patients with the best care.
To do this, it is essential that your health record is kept up to date and accurate.
ALL patients are asked to complete the following.

Title: Mr Mrs Ms Miss Mast Dr Other ....

Preferred Pronouns: He/Him She/Her They/Them

Family Name:.. **Given Name:** ....

Middle Name:.. **Preferred Name:** ....

Date of Birth: .... **Occupation:**...

Do you identify yourself as: Aboriginal Torres Strait Islander Both Neither

Address:...

.... **Postcode:** ....

Home No: .... **Work No:**...

Mobile No: .... **Email:** ....

Next of Kin: *Best person for us to contact on your behalf in the case of an emergency.*

Full Name: .... **Relationship:** .... **Phone:**.......................................

Emergency Contact:

Full Name: .... **Relationship:** .... **Phone:**.......................................

Medicare Number: .... Ref: .... Exp: ..../............

Pension Health Care Card
Commonwealth Seniors Health Card : .... Exp: ..../.........../..........

Dept. of Veterans' Affairs: .... Exp: ..../.........../........... Colour: ....

Please ensure you also complete the next page

Health Information Collection and Use Consent Form

Grove Family Health

281 Torquay Road, Grovedale. VIC, 3216

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat, and be proactive in your health care needs.

We aim to protect the privacy and secure storage of 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.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- 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 and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research, teaching 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 will identify you be required, you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legal, legislative or regulatory requirements e.g.,notifiable diseases or when required by court of law.
- For reminder or recall letters/emails/SMS which may be sent to you regarding your health care and management.
- To access and submit immunisation, bowel and cervical screening data to the Australian Immunisation Register and the National Cancer Screening Register.

Please read this consent form carefully, and sign where indicated below.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

- I have read the information above and understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

By signing below I agree and consent to the information listed above.

Patient's name: .... **Date:** ....

Patient's signature: ....

Signed as Guardian for child: ....

Name of Guardian: (printed) ....

Grove Family Health
281 Torquay Road, Grovedale, VIC 3216
Ph: (03) 4245 2181 Fax: (03) 4245 2191
email: reception@grovefamilyhealth.com.au