NEW PATIENT REGISTRATION FORM

Please fill out **both sides** of the form in capital letters

ROKEBY GP
A Better Experience

TITLE _____ SURNAME _____ GIVEN NAMES _____

PREFERRED NAME _____ DATE OF BIRTH ____/____/____ BIRTH SEX: Male or Female

GENDER IDENTITY _____ PREFERRED PRONOUNS She/Her/Hers He/Him/His They/Them/Theirs

Please circle: ABORIGINAL TORRES STRAIT ISLANDER NEITHER

COUNTRY OF ORIGIN _____

ADDRESS _____

SUBURB _____ POSTCODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE _____

EMAIL _____

FAITH _____ OCCUPATION _____

Please list other family members who currently attend Rokeby GP or would like to attend.

Name	Date of Birth	Medicare No	Medicare Line No

ALLERGIES Do you or any of your family members listed above have allergies? YES ☐ NO ☐

Reception initial

PATIENT NAME	PRODUCT	REACTION	SEVERITY

Administration use only
The above allergies have been entered in 'Electronic Patient Record' Nurse signature _____

MEDICARE CARD HOLDERS

Card # ☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Medicare Line Number (number before your name on Medicare card) ☐ Expiry Date /

IDENTIFICATION – (Medicare and Non Medicare Holders) Please provide identification to reception

Administration use only. Identification been sighted. Administration signature _____

Medicare card ☐ Other ☐

HEALTH CARE CARD/ PENSIONER CONCESSION CARD/ COMMONWEALTH SENIORS HEALTH CARD

_____ Expiry Date _____

DVA PATIENTS Card Number _____ Gold / White

NEXT OF KIN

FULL NAME _____ RELATIONSHIP TO YOU _____

CONTACT PHONE NUMBERS _____

EMERGENCY CONTACT (Different to above)

FULL NAME _____ RELATIONSHIP TO YOU _____

CONTACT PHONE NUMBERS _____

CONSENT AND DECLARATION

I declare that I have answered the above questions accurately and to the best of my knowledge.

I understand that ROKEBY GP complies with the Privacy Act (1988) and as a part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical & health related services and associated account keeping.

I understand that I have the right to request access to my information except where access would be denied and that ROKEBY GP makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for ROKEBY GP to use and disclose my personal information (except when legal obligations must be met) following a discussion with the doctor.

I consent to ROKEBY GP collecting, using, storing & disposing of my personal information and releasing relevant information to other Health Professionals to allow quality medical care. In the case of workers compensation claims or pre-employment medical related consultations I consent to the release of relevant personal information to my employer, their authorised representatives and their insurer.

I consent to the inclusion on the ROKEBY GP recall reminder register.

I acknowledge I may receive correspondence by telephone, post, email or sms for follow up visits requested by the doctor, appointment reminders, medical updates and health information from ROKEBY GP.

I understand that all accounts must be paid at the time of the consultation.

I am responsible for all accounts of any children under the age of 16 years who I am listed as their next of kin.

I am in receipt of a ROKEBY GP Practice Information Sheet.

I acknowledge that ROKEBY GP charges a fee for non-attendance and late cancellations of less than 2 hours' notice.

I acknowledge that ROKEBY GP is a Private Billing Practice.

PATIENT (or Guardian) SIGNATURE _____ DATE _____