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 _____ Male or Female

ARE YOU ABORIGINAL/TORRES STRAIT ISLANDER? Yes or No COUNTRY OF ORIGIN _____

ADDRESS _____

SUBURB _____ POSTCODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE _____

Please tick preferred phone number for test results/surgery phone calls HOME ☐ WORK ☐ MOBILE ☐

FAITH _____ OCCUPATION _____

ALLERGIES Do you or any family member listed below have any 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

Administration use only. Identification been sighted. Administration signature _____

Medicare card ☐ Other ☐

Please list other family members (under 16 only) you would like to or who attend Rokeby GP

Name	Date of Birth	Medicare No	Medicare Line No

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.

EMAIL _____

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 PARENT/GUARDIAN SIGNATURE _____ DATE _____