DR EMMA READMAN
PATIENT REGISTRATION

Welcome. Would you please fill in the following details.
Please ring through any information you cannot presently provide

PERSONAL DETAILS

Title Mr / Mrs / Ms / Miss / Master /Other …… First Name ……

Surname ……

Middle Name …… Known as ……

Address ……
(Number) (Street) (Suburb) (Postcode)

Telephone …… …… ……
(Home) (Work) (Mobile)

Date of Birth ……/……/…… Marital Status ……

Partner's Name …… Partner's Date of Birth ……/……/……

GP ……

Address …… Ph. ……

ACCOUNT DETAILS

Medicare Number Your number on the card

Expiry Date ……/……

Do you have Private Health Insurance (Circle) **YES** **NO**

If yes, Name of Fund ……

Membership No……

Person responsible for paying accounts ……

Veteran's Affair's Gold Card No. ……

HCC or Pension Card No ……

EMERGENCY CONTACT

Person to notify in an Emergency

First Name …… Surname ……

Relationship to you ……

Telephone …… …… ……
(Home) (Work) (Mobile)

I agree to pay all accounts within this practice's specified time period. In the event of late payment the practice reserves the right to charge an accounting fee.

Signature …… Date ……/……/……

PRIVACY INFORMATION – Please read and sign reverse side

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Provider No: 210670EX

Your Health Information and Our Privacy Policy

In accordance with the Victorian Health Records Act 2001 and Federal Privacy Act 1988

Our practice respects your right to privacy. We realise that it is important that you understand the purpose for which we collect details about your health, as well as how this information is used at our practice and to whom this information might be disclosed.

The policy of our practice is to follow these procedures:

1. The information collected will be used for the purpose of providing treatment to you. Personal information such as your name, address and health insurance details will be used for billing purposes including compliance with Medicare and Health Insurance Commission requirements. We also need this information to write to you about our services and any issues affecting your treatment.

   We may disclose your health information to other health care professionals, or require it from them, if, in our judgement, that is necessary in the context of your treatment.

2. Your medical history, treatment records, pathology results, ultrasound results and any other material relevant to your treatment will be kept here. You may inspect or request copies of our records of your treatment at any time, or seek an explanation from the doctor. Statutory fees will apply in relation to the types of access you seek. If you request an explanation of our records or a written summary, our usual fees apply to these services.

3. If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

You can otherwise rest assured that your health information will be treated with the utmost confidentiality. Disclosure will not be made to any person not involved in either your treatment or the administration of this practice, without your prior written consent. If you have any queries or concerns about our handling of your health information, please do not hesitate to raise these concerns with our practice.

Patient Acknowledgement

I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment that I want.

I am aware that I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand 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, permission, in writing, will be sought first.

I acknowledge that I have read this form before signing it and that a member of staff of this practice has, at my request clarified any aspects of it that I did not at first understand.Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in this way.

Signed: ……

Date: ……

Patient Name……..