REHOBOTH MEDICAL CENTERS
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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.

Could you please assist us by completing the following?	
Title	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master
Surname	
Given Name	
Preferred Name	
Date of Birth	
Gender	☐ Male ☐ Female ☐ Other ☐ Prefer not to specify
Ethnicity	
Home Address	
Suburb and Post Code	
Home Phone	
Work Phone	
Mobile Phone	
Email	
Occupation	

Medicare Number:	#: Ref	Expiry:
☐ **DVA Gold** ☐ **DVA White** (Please tick which)	#:	Expiry:
Pension Number	#:	Expiry:
Health Care Card number	#:	Expiry:
Private Health Cover	Name: #:	

Next of Kin	Name: Relationship: Home phone: Mobile phone: Work phone:
Emergency Contact	Name: Relationship: Home phone: Mobile phone: Work phone:

Reminder Systems

Our practice provides our patients with preventive care and early case detection reminders e.g. immunizations, annual health checks, skin checks and pap smears.

Preferred method of contact and appointment reminders?	☐ SMS ☐ Email ☐ Home phone ☐ Work phone ☐ Mobile Phone

Patient Background

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?
☐ Neither
☐ Aboriginal
☐ Torres Strait Islander
☐ Aboriginal & Torres Strait Islander

Allergies

Do you have ANY ALLERGIES or are you sensitive to drugs or dressings?
☐ No
☐ Yes. Please elaborate:

Social History

Do you use any of the following: (list amount where appropriate)	
Tobacco	☐ No. ☐ Yes. Number: _____ per day/_____ per week / _____ per month ☐ Ceased smoking. Month and year ceased: / /
Alcohol	☐ No. ☐ Yes. Number _____ per day/_____ per week / _____ per month
Drug Use	☐ No. ☐ Yes. Type: _____ Frequency: _____

The policy of this practice is to follow these procedures: • The information collected by us will be used for the purpose of providing medical treatment to you. Personal information such as your name, address and health insurance details will be used for the purpose of performing pathology investigations, processing payments and writing to you about any issues affecting your treatment and care. You have the right to deal with us anonymously or under a pseudonym unless it is impracticable for us to do so or unless we are required or authorized by law to only deal with identified individuals. • We may also discuss your health information to other healthcare professionals or require it from them, if in our judgment, it is necessary in the context of your treatment and care. In certain situations, e.g notifiable diseases, we are required by law to disclose relevant health information to government departments. Information can also be collected through electronic transfer of prescriptions (eTP), My Health Record, eg via Shared Health Summary, Event Summary. We may also collect your personal information when you visit our website, send us an email or SMS, telephone us, make an online appointment or communicate with us using social media. We do not send or share the personal information outside of Australia. • Your patient history, any correspondence, pathology reports, imaging reports etc. and any other material relevant to your treatment and care will be kept here. You may inspect or request a copy or summary of your medical notes. A written request is required for the privacy and security reasons. Should you personally want a copy or summary, a fee will apply. If you request to see your notes, you will need to prearrange an appointment with one of the doctors. If the information we have about you is inaccurate, you may email us to alter our records accordingly. Our practice will respond with 28 days for such requests for records to be transferred. Your health information will be treated confidentially, Disclosures will not be made to any person outside of this Centre) unless it relates to the above points without your prior written consent. If you have any queries or concerns about the handling of your health information, please do not hesitate to raise your concerns with us. You can ask for a copy of our Privacy policy. Please sign this form as confirmation that you have read and understood our billing policy, privacy policy, and consent to the use of your health information in the above way. Name

Signature: _____

Date: _____/_____/_____