The University of Melbourne Shepparton Medical Centre

Patient Registration Form

When completed, Please give to a reception team member

We are committed to providing our patients with the best care. To do this, it is essential that your health record contains complete and accurate information. Please assist us by completing your new patient record form:

Patient Information			
Title:	Ms Miss Mrs Mr Mstr Dr Prof Other?		
Surname:			
First Name:		Middle Name:	
Preferred Name:		Date of Birth:	____/____/_____
Gender:			

Cultural Identity

To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal and Torres Strait Islander

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and appreciation between all people - do you identify as someone from a culturally and/or linguistic diverse background? ☐ No ☐ Yes , *If yes, please identify ethnicity*_____

Contact Information			
Street Address:			
Postal Address: *(if different to above)*			
Home Phone:			
Mobile Phone:		Work Phone:	
Email:			

Healthcare Identifiers

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref: _____ Expiry: _____/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: _____ Expiry: ____/___/____

Health Insurance Fund	Policy #

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Head of family – If registering a child, include parent/guardian contact details.	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	
Next of Kin	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	
Emergency Contact Details	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	
Occupation	
Occupation Title.	
Authorised person - #1	
I authorise the following person to act on my behalf in regards to accessing my records, results and other information that may be held at the clinic.	
Name	Relationship to you:
Contact details/ Phone/email	
Authorised person - #2	
I authorise the following person to act on my behalf in regards to accessing my records, results and other information that may be held at the clinic.	
Name	Relationship to you:
Contact details/ Phone/email	
Interpreter	
Do you require an interpreter? ☐ No ☐ Yes If so, please specify what type / language _____	
Student Consent	
Are you willing to have a medical/ health student in attendance at your consultations? **YES** ❒ **NO** ❒	

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Patient Consent Form

Health Information Collection, Use and Disclosure

Please read this carefully prior to signing.

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

This general practice collects information from you for the primary purpose of providing our patients with quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to provide you with sufficient information on how your personal information (including health information) may be used or disclosed and record your consent or restrictions to this consent.

Your personal information will only be used for the purposes for which it was collected or otherwise permitted by law, and we respect your right to determine how your information is used or disclosed. At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important, and we will take all steps necessary to ensure they remain confidential.

The information we collect, may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare details, data collected from observations and conversations with you, and details obtained from other healthcare providers (e.g. specialist correspondence).

Please refer to our privacy policy https://shepmed.unimelb.edu.au/patients/your-rights-And-responsibilities *for more information generally on the management of personal information (including health information) by this general practice.*

By signing the acknowledgement and consent below, you (as a patient/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- *Administrative purposes in the operation of our general practice.*
- *Billing purposes, including compliance with Medicare requirements.*
- *Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.*
- *Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, updating your My Health Record, to prescribe your medications electronically (meaning you do not need a hand-held script) or for medical tests and in the reports or results returned to us following the referrals.*
- *Accreditation and quality assurance activities to improve individual and community health care and practice management.*
- *For legal related disclosure as required by a court of law.*
- *For the purposes of research only where de-identified information is used.*
- *To allow medical students and staff to participate in medical training/teaching.*
- *To comply with any legislative or regulatory requirements, e.g. notifiable diseases.*
- *For use when seeking treatment by other doctors in this practice.*

As part of this general practices commitment to providing quality health care, we have implemented technology solutions to enable communications with our patients via SMS and mobile applications.

In addition to other communications we may send you from time to time, we may send you the following types of communications:

1. ***appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
2. ***clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
3. ***clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*
4. ***health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*

Patient Consent Form

Health Information Collection, Use and Disclosure

Please read this carefully prior to signing.

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications below. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.
To the extent practicable, we will send you communications via your preferred contact method indicated below. However, you acknowledge that we may contact you using any of your contact details that you may provide to us from time to time as we consider appropriate.

Acknowledgements and Consent
I acknowledge and agree that, in the course of providing health care services to me, the general practice must collect and may need to use and disclose my personal information (including any health information) as set out in this form. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I wish to receive health awareness communications (as described above) and I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receipt of such health awareness communications. ☐

My preferred contact method for all communications is:

Phone ☐ Letter ☐ SMS ☐ App ☐ Email ☐

I acknowledge that there are risks associated with some methods of electronic communication and that my privacy and confidentiality may be compromised.
I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.
I understand that only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: _____ Date Of Birth: _____

Parent/Guardian Name (if Patient is under 16) _____

Signature: _____ Date: _____

PRACTICE USE ONLY
Witnessed by: (staff signature) _____