New Patient Registration Form

Hanover Street Medical Centre

oMr oMrs oMs oMiss oMaster

Surname: _____First Name: _____Date of Birth: ____/____/____

Postal Address: _____Suburb: _____Postcode: _____

Home Phone: _____ Mobile: _____ Work: _____

Email address: _____

Medicare number or DVA number: _____

Reference number (next to name):_____ Card expiry:_____

Pension or Centrelink Health Care Card Number: _____ Card expiry: _____/_____

Ethnicity: oAustralian oAboriginal/Torres Strait Islander oOther _____

Personal Status: oMarried oDefacto oSingle oDivorces/Separated oWidowed

Emergency contact person: _____ Relationship to patient:_____

Mobile: _____ Home Phone: _____

oAs Above

Next of kin contact person: _____ Relationship to patient:_____

Mobile: _____ Home Phone: _____

Recalls: Do you consent to receiving recalls and reminders via SMS or email? oYes oNo

CONSENT:

I hereby consent to abide by the following terms and conditions of the Hanover Street Medical Centre:

FEES & CHARGES: I agree to pay all fees and charges that may not be covered under Medical Benefit Scheme or under mandatory Work Cover insurance maintained by my employer. In the event of late payment, the practice reserves the right to charge a reasonable account management fee that may apply.

PRIVACY PROTECTION: The Hanover Street Medical Centre respects your rights under the "Privacy Act 1988" and upholds your rights to privacy protection under Australian Privacy Principles contained in the "Privacy Amendment (Private Sector) Act 2000.

PREVENTATIVE HEALTH: Our practice provides our patients with preventative care and early care detection reminders e.g. immunisations, annual health checks, investigation recalls, skin checks and pap smears. If you do not wish to have reminder letters sent to you, please inform reception.

e-HEALTH: The Hanover Street Medical Centre participates, collects, and complies with all the National E-Health Transition Authority (nehta) initiatives for electronically connecting the points of care so that your health information can be shared securely. We do so to help nehta in facilitating the transition to a connected system where every Australian is at the center of their healthcare.

Patient / Guardian Signature: _____ Date: _____

Please print name: _____