ocean
FAMILY MEDICINE

NEW PATIENT REGISTRATION FORM

Surname			
First Name		Mr □ Mrs □ Ms □ Dr □ Other:	
Date of Birth			
Street Address			
Suburb		Postcode	
Home phone		Mobile phone:	
Work phone		Email:	
Gender	Male □ Female □	Marital status: Single□ Married □ Widowed □ Defacto □ Separated □	
Occupation			
Emergency contact (Name & phone no.)	Name: Address:	Phone no: Relationship:	
Country of birth		Ethnic background:	
Do you identify as Aboriginal or Torres Strait Islander?	Aboriginal □ Torres Strait Islander □ NCACCH no:		
What is your primary language?	English □ Other:		
Medicare number		Expiry:	Ref no.
DVA Gold/White number		Expiry:	
Pension card number		Expiry:	
Health care card number		Expiry:	
Do you consent to receiving SMS texts for reminders?	Yes □ No □		

HEALTH COLLECTION AND CONSENT FORM

In order to provide you with the highest standard of medical care, Ocean Family Medicine is required to collect personal information about you and to use that information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes to assist in the running of Ocean Family Medicine.
- Billing purposes, including compliance with Medicare requirements.
- Sending health record information to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to your doctor following referrals.
- Sharing your health information with other doctors in this practice, locums etc. attached to the practice for the purpose of patient care.
- For research and quality assurance activities to improve individual and community health care and practice management. This may mean at times de-identified (anonymous) information may be collected.
- For Ocean Family Medicine's recall and reminder letters/texts which may be sent to you regarding your healthcare and management. Also consent for State and National recall and reminder systems.

We protect the privacy and secure storage of your health information.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your healthcare to provide the best outcome for you.

Patient Name: _____ Patient Signature: _____

Signed as Guardian for child: _____ Name (printed): _____

Date of Birth _____ Today's Date: _____