Patient Registration Form – New or Updated Details

PATIENT DETAILS:

Title:

Family Name:

Given Name: | Preferred Name/s:

Date of Birth: | Sex: ☐ Male / ☐ Female / ☐ Other

Address: | Is this your postal address: ☐ Yes / ☐ No
If no, please provide postal address:

Mobile: | Home Phone: | Work Phone:

Email address: | Do you require an Interpreter: ☐ No / ☐ Yes

Are you: ☐Australian, non-indigenous ☐Aboriginal but not Torres Strait Islander ☐Torres Strait Islander but not Aboriginal ☐Both Aboriginal and Torres Strait Islander ☐ Not stated **OR** Country of Birth:

IDENTIFIERS:

Medicare Card #: | Position on the card: | Expiry: ☐☐ / ☐☐☐☐

Do you have a Concession card? ☐ Yes / ☐ No

Pension/HCC Card No: | Card Type: | Expiry:

DVA Card No: | Card Type: | Expiry:

Private Health Insurer:

FAMILY INFORMATION:

Next of kin *(Please enter below)* | **Is this person also an emergency contact?** ☐ Yes / ☐ No

Name: | If no, please provide details for emergency contact

Phone Number: | Name: | Relationship to you:

Relationship to you: | Phone Number:

SOCIAL DETAILS:

Occupation: | Student: (18 & over) ☐ Yes **if yes, please show ID card to reception*

Do you have a MyHealthRecord (previous PCEHR): ☐ Yes / ☐ No

ADDITIONAL INFORMATION:

I give my consent for information regarding my treatment to be released to other health care providers involved in my care as necessary and I accept the privacy risk where my information is provided by fax or unencrypted/unprotected email, as the information may be intercepted, sent to the wrong person or read by and unintended recipient.
Langmore Clinic acknowledges and respects the privacy of individuals. The personal information collected is necessary for us to provide you with the best possible service. By completing this form, Langmore Clinic accepts that you, your parents/guardians (if person is under 16 years of age) have consented for this information to be collected. The intended recipients of this information are Langmore Clinic and its authorised staff. You have the right to access and alter personal information collected in accordance with the Commonwealth Privacy Act, a copy of our privacy policy is available from the practice.

SIGNATURE: _____ **DATE:** _____

I agree to the terms & conditions of registration with Langmore Clinic.
For further information, refer to our patient information sheet. Our practice uses email & SMS for health, appointment reminders or communications.
Please tick if you do NOT wish to be contacted in this way: Appointment Reminders ☐ Results ☐ Clinical Reminders ☐ Health Awareness ☐

OFFICE USE ONLY	
CHECKED BY:	
DATE RECEIVED:	/ /
OPV/MEDICARE & HI CHECKED	

LANGMORE CLINIC