53 Ruby Street, Emerald 4720
PH: (07) 4910 7800 | Fax: (07) 3040 4434
E: myGP@priorityhealthgroup.com.au
www.priorityhealthgroup.com.au | www.dermdoctor.com.au

New Patient Registration & Information Form

At Priority Health Group we are committed to provide quality, personalised and professional health care.

Title:	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Other: ____________		
Family Name:			
Given Name:		**Middle Name:**	
Preferred Name:			
Date of Birth: _____/_____/_____		**Sex:** ☐ Male ☐ Female ☐ Non-Binary	
Ethnicity: Do you identify as ☐ Aboriginal or ☐ Torres Strait Islander or ☐ both		☐ Other : ________________________	
Street Address:			
City/Suburb:		**Postcode:**	
Postal Address: (*if different to above address*)			
Occupation:			
Home PH:	**Work PH:**	**Mobile:**	
Contact Via:	☐ Home PH ☐ Mobile ☐ Work PH ☐ SMS ☐ Email ☐ Letter		
Email:		☐ Consent to SMS reminder	☐ Consent to Email reminder

Medicare No.: ____________________	**IRN:** _____	**Expiry:** ___/_____/_____
Pension Card Type: ☐ Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card		
Pension Card No.		**Expiry:** _____/_____/_____
DVA No.:	☐ Gold ☐ White ☐ Lilac ☐ Orange	
Private Health Insurance/Fund:		
Health Insurance No.:		

NEXT OF KIN:			
Title :	First Name :	Surname :	
Address :		Phone :	Mobile :
City/Suburb :	Postcode :	Relationship to Patient :	
EMERGENCY CONTACT: (*If different to Next of Kin*)			
Title :	First Name :	Surname :	
Address :		Phone :	Mobile :
City/Suburb :	Postcode :	Relationship to Patient :	
☐ Registered for CTG PGS Co payment relief			

General/Other Information :

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PATIENT CONSENT FORM

Priority Health Group, Emerald Surgery and DermDoctor Skin Cancer Clinic (the Practice) requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes and sign below.

This Practice collects information for the primary purpose of providing 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, treat and be proactive in your health care needs.

I understand that the Practice complies with the Privacy Act (1988) and as a part of our Privacy Policy, we are committed to protecting the privacy of individuals and your personal information.	☐
I consent for my personal health information to be used for administrative purposes to assist in the running of this Practice, including disclosure to others involved in my healthcare, such as treating doctors and specialist within and outside this medical practice. (This may occur through referrals to other doctors and specialists, or for medical tests and in the reports or results returned to my doctor following referrals).	☐
I consent to the inclusion on this Practice's recall reminder register. I acknowledge I may receive correspondence by telephone, post, email, HotDoc push notifications or sms for follow up visits requested by the doctor, appointment reminders, medical updates and health information from this Practice.	☐
I understand that I have the right to request access to my information except where access would be denied and that this Practice makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent from this Practice to use and disclose my personal information (except when legal obligations must be met) following a discussion with the doctor.	☐
I give my consent to the presence of a third party to be present during my consultation. (This may include a practice nurse, medical student, doctor in training or supervising doctor)	☐

I understand that by ticking the relevant boxes above that the Practice is authorised on my behalf to use my personal health information and I am free to withdraw my consent at any time by verbal or written notification.

Name of Patient: ____

Signature of Patient: ____

Print name and signature of Parent/Guardian (if patient under 18): ______________________________

Date: ______/ _______ /_______