

New Patient Registration & Information Form

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

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

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|--|---|-------------------------------|
| Medicare No.: _____ | IRN: _____ | Expiry: ____/____/____ |
| Pension Card Type: <input type="checkbox"/> Pensioner Concession Card <input type="checkbox"/> Health Care Card <input type="checkbox"/> Commonwealth Seniors Health Card | | |
| Pension Card No. | Expiry: ____/____/____ | |
| DVA No.: | <input type="checkbox"/> Gold <input type="checkbox"/> White <input type="checkbox"/> Lilac <input type="checkbox"/> 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 : | |
| <input type="checkbox"/> Registered for CTG PGS Co payment relief | | | |

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| 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. | <input type="checkbox"/> |
| 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). | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> |
| I understand that it is my responsibility to follow-up my referral with referred doctor/hospital | <input type="checkbox"/> |
| 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). | <input type="checkbox"/> |
| I consent to the use of medical scribe software during my consultation, which may be used by the doctor to assist in transcribing and documenting clinical notes | <input type="checkbox"/> |
| I hereby consent to the use of DermEngine to take and store clinical photographs of my skin condition(s). I understand that these images may be shared with specialist(s) for the purpose of opinion, diagnosis, clinical review, or specialist referral, if deemed necessary by my treating practitioner. | <input type="checkbox"/> |

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: ____ / ____ / ____