# Registration Form

## New Patients

MORELAND WEST MEDICAL CENTRE

Caring well

We require this information to provide the best quality health care. Your personal health information is kept private and secure, as required by federal and state privacy laws. You can view a copy of the Australian Privacy Principles at https://www.oaic.gov.au/privacy/australian-privacy-principles/read-the-australian-privacy-principles which includes information about the collection, use and disclosure of your health information.

When you have completed the form, please email to reception@mwmedicalcentre.com.au.

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## Section A: **Personal Details**

Title | Family Name | Given Name | Middle Name

Mr

Preferred Name | Date of Birth | Gender | Pronoun

Female | She/Her/Hers

Occupation

Home Address (not PO Box) | Post Code

Postal Address (if different from above) | Post Code

Home number | Work Number | Mobile Number

Email

Medicare Card Number | Medicare reference no. | Medicare expiry date

Do you have a Pension or Health Care Card? | Card Number | Card expiry date | Card Type

No | N/A

Do you have a Veterans Affairs Card? | Card Number | Card Type

No | N/A

**Next of Kin**

Name | Relationship to you

Contact Number

**Who can we contact in case of an emergency?**

Name | Relationship to you

Contact Number

**If 16 and under, who is your primary carer?**

Name

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## Section B: **Cultural Details**

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Were you born in Australia?

Yes ☐ No ☐

Are you of Aboriginal or Torres Strait Islander origin?

No - Australian, non-indigenous

Ethnicity/Country of Birth

Is English your first language

Yes ☐ No ☐

If no, do you require an interpreter?

Yes ☐ No ☐ Language

## Section C: **Other**

How did you hear about us?

Word of Mouth

## Section D: **Consent**

Please read this information carefully, and sign where indicated below. Moreland West Medical Centre collects information from you 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.

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Administrative purposes in running our medical practice;
- Billing purposes, including compliance with Medicare requirements;
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals;
- Disclosure to other doctors, medical students and other team members working within this practice;
- To comply with any legislative or regulatory requirements e.g. notifiable diseases; and
- For our recall and reminder system to assist us in your ongoing health care and management.

I have read the information above and understand the reasons why my information must be collected. ☐

I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me. ☐

I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances. ☐

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained. ☐

I consent to be contacted via post, telephone, email or SMS for the following: ☐

- Appointments
- Tests & Results
- Reminders
- Health Awareness

Signature of patient or guardian

Date

Submit