NEW PATIENT REGISTRATION FORM

(Please ensure that you complete all sections of this form and hand back to receptionist ASAP)

Title: _____________ **Given Name**:_________________ **Surname**:______________________________

Sex: Male / Female / Intersex/ Transgender	Medicare No:__________________________
Date of Birth: / /	Patient No: ☐
Address:_______________________________ _______________________________________	Expiry Date: /
Phone No:__________________________	Health Care Card No______________________________
Mobile No:____________________________	Expiry Date: /
Agree to receiving SMS: Yes / No	Pensioner Concession Card No:___________________
Marital Status:_________________________	Expiry Date: /
Occupation:____________________________	Veteran Affairs No:_______________________________
Ethnicity______________________________	
Country of Birth:	

Next of Kin:____

Relationship of next of kin____

Next of Kin Phone No:____

Emergency Contact Phone No:____

Emergency Contact Name (if different from next of kin):___________________________________

Are you Aboriginal or Torres Strait Islander: Yes / No If yes, please indicate whether you are: ☐ Aboriginal Torres Strait Islander ☐ Aboriginal & Torres Strait Islander	For children under 18 Parent/Guardian Name:___________________________ Date of Birth of Parent / Guardian / / Address:____ Medicare No:____________________ Patient Number ___ Expiry Date:_______________________________

Lsc 11A
Last Reviewed 11 March 2020

Payment is required at time of consultation

We accept Cash, Cheque, EFTPOS & Credit card. ***Amex and Diners not accepted***

PATIENT CONSENT FORM

Livingstone Street Clinic requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes, and sign where indicated below.

This Medical 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 give my permission for my personal health information to be used for administrative purposes to assist in the running of Livingstone Street Clinic, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Clinic. (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 give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. (This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.)

I give my consent for my personal health records to be used for unidentifiable patient health information. (This may occur when the Practice participates in research activities on behalf of a university as part of professional development activities. Identifiable patient information can possibly be traced back to the individual.)

I give my consent to the presence of a third party to be present during my consultation. (This may include a Practice Nurse or medical student.)

I give my consent to be part of the Practice's National, State and Territory recall and reminder systems.

I understand that by ticking the relevant boxes above that the Practice is authorized 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 ______________________________