Meadowbrook Medical Centre

Patient Registration Form

Please Note: UQ Health Care's company policy is that on your initial visit, or at any time at the GP's discretion the GP will not be able to write a prescription for any medication that the GP deems to be "Drugs of Dependence".

Title	Dr Prof Mr Mrs Miss Ms Master Other _____		
Surname			
First Name/s		**Known as**	
Date of Birth	/ /	**Gender**	☐ Male ☐ Female
Ethnicity	Example: Australian, Aboriginal, New Zealander, Chinese, English, Japanese		
Street Address			
Suburb		**Postcode**	
Postal Address ☐ Same as above			
Suburb		**Postcode**	
Home Phone	( )	**Work Phone**	
Mobile Phone			
Email	@		
Medicare Card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	No. next to name **Ref No.** ___	Month / Year **Expiry Date** /
Pensioner Card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry Date** / /	
Health Care Card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry Date** / /	
DVA ☐ Gold ☐ White	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry Date** / /	
Private Health Fund	Fund Name: Fund No.__ __ __ __ __ __ __ __ __ __ __	**Expiry Date** (if known) / /	
OSHC/World Care Educover	☐ OSHC Worldcare ☐ Worldcare Educover ☐ Single ☐ Family ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiry Date / /		
Parents Details (Only if Patient is under 16yrs)	Name: Address: Suburb: Postcode: Date of Birth: / / Medicare Card No. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No. ___ Exp Date /		
Next of Kin	First Name: Surname: Telephone: Relationship:		
Emergency Contact (Person not in the same household)	First Name: Surname: Telephone: Relationship:		
Patients Occupation			

If we need to contact you what is your preferred method of contact: *(please tick **one** only)*

☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email ☐ SMS

PLEASE TURN OVER

Meadowbrook Medical Centre

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes – Please explain……..

☐ What is your preferred language (if not English)……

To assist with health initiatives – are you Aboriginal or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander

PRIVACY OF PATIENT INFORMATION

Our Practice collects personal information and sensitive health information about you and safeguards its confidentiality and privacy in accordance with National Privacy Principles. UQ Health Care's Privacy Policy is available on request, and on display in our waiting room areas.

I acknowledge that my personal information may (where required) be disclosed to other health providers and practitioners so that my health care is not compromised. This information may also be disclosed to other statutory authorities, including insurers and in circumstances where required by law.

Name (please print): ……..

Signature: ……. Date: …...../……/……..

YOUR HEALTH DATA

I give permission to UQ Health Care to store, analyse and publish information collected during my treatment for the purpose of increasing medical and scientific understanding and for educational purposes. I understand that in the event my information is used for the above-mentioned purposes, my identity remains confidential and the information used does not convey my identity under any circumstances.

I consent / do not consent (please circle appropriate) to my health information being used for purposes in the above-mentioned paragraph.

Name: (please print): ……...

Signature: ……Date: ……../……/……..

CONSENT

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by **post**, **email**, **phone** or **SMS** for procedures such as vaccinations, cervical screening, skin checks and other health reviews.

I consent to being contacted with reminders and health promotions to help me maintain my health.

Yes ☐ **No** ☐

Our practice also sends information to the Australian Childhood Immunisation Register and National Cervical Cancer Screening Register. These registers also send reminders, which can be helpful if you move.

Signature of patient/guardian:_____ Date: …….. /……/…….