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		**Date of birth:** ____ / ____ / _____	
First name/s		**Known as:**	
Birth sex	☐ Female ☐ Male ☐ Intersex	**Gender identity**	☐ Man ☐ Gender diverse ☐ Woman ☐ Non-binary ☐ Transgender man ☐ Transgender woman ☐ Other _____
Ethnicity	Example: Australian, Aboriginal, New Zealander, Chinese, English, Japanese		
Street address			
Suburb		**Postcode:**	
Postal address	☐ Same as above		
Home phone		**Work phone:**	
Mobile phone		**Email:**	
How did you hear about us?	☐ Social media ☐ Google search ☐ Word of mouth ☐ Digital ad ☐ Outdoor signage ☐ Newspaper/magazine ☐ Billboard		
Preferred contact method (Please select one only)	☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email ☐ SMS		
Occupation			
Medicare Card	__ __ __ __ __ __ __ __ __ __	**Ref no. :**	**Expiry date:** ___ / ___
Pensioner Card	__ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____	
Health Care Card	__ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____	
DVA Card ☐ Gold ☐ White	__ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____	
Private Health Fund	__ __ __ __ __ __ __ __ __ __ __	**Expiry date:** ___ / ___ / ____ **Fund name:**	

Please turn over

OSHC/World Care Educover	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ OSHC Worldcare ☐ Worldcare Educover ☐ Single ☐ Family	**Expiry date:** ___ / ___ / ____
Parents details (Only if patient is under 16yrs)	Name: _____ Street Address: _____ Suburb: _____ Postcode: __ __ __ __ Date of birth: ____ / ____ / _____ Medicare card number: __ __ __ __ __ __ __ __ __ __ Ref number: _____ Expiry date: ___ / ___	
Next of kin	First Name: _____ Surname: _____ Phone: _____ Relationship to you: _____	
Emergency contact (person not in the same household)	First Name: _____ Surname: _____ Phone: _____ Relationship to you: _____	

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?**

☐ No

☐ Yes – **Please explain:**

_____

What is your preferred language? (if not English):

_____

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

Are you of Aboriginal or Torres Strait Islander origin?

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

Please turn over

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*** / ☐ ***I do not consent (please tick appropriate response) 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: _____ / _____ / _____