Hamilton Family Practice - Patient Registration & Privacy Form

ABN 50 415 094 291

130 Lonsdale Street, Hamilton, VIC 3300

Ph.no: 03 5572 5592

Surname:					
Given Name:					
Mr/Mrs/Ms/Miss/Mast		**DOB**		**OCCUPATION**	
Medicare Card No:			**Ref. No.**	**Expiry:**	
Pension Card No:			**Expiry:**		
Health Care.Card No:			**Expiry:**		
Veteran Affairs Card No:			**Type of Card:**	**Expiry:**	
ADDRESS:				**Postcode**	
PHONE	**H**		**W**	**MOB**	
Are you willing to be contacted by	**SMS**	**Y / N**	**EMAIL:**		

Country of Birth:

Are you Aboriginal or Torres Strait Islander (ATSI)?

Allergies: Are you allergic or sensitive to any medications? Y/N? If so please list.

Emergency Contact:

In case of emergencies who should we contact? Please list all emergency contact numbers including Home (H), Work (W), Mobile (M) for your emergency contact.

Name: .....

Relationship:.....

Contact No: .....

Social History:		***Family History***
Do you smoke? How many per day? Have you smoked previously? Quit Date?		Married De facto Single N/A
Drink Alcohol? How many per day/wk?		**Significant Medical conditions in your family:**
Do you want to Quit any /all of the above?		

Confidential Past Medical History:	
Have you ever been a patient in a hospital? If so, for what reason?	
Are there any chronic disease/s you have suffered or currently suffer from?	
Do you take regular medication? Please list	

P.T.O

Privacy Agreement & Patient Consent:

I understand that Hamilton Family Practice and associated Medical Centres comply with the privacy Act (1988) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Hamilton Family Practice collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service.
I understand I may withdraw my consent for Hamilton Family Practice to use and disclose my personal information (except when legal obligations must be met).

I am aware and understand the administration fee structure. I consent to pay the ONE OFF administration fee to avail the services.

Financial Consent:

I agree that the above is true and accurate record. I understand that Hamilton Family Practice requires on the day of treatment, although we are a Bulk Billing practice there are occasions we may have to invoice you for consumables and surgical fees etc.... The fees need to be paid on the day of the treatment. Any expenses or costs incurred by Hamilton Family Practice in recovering outstanding money including debt collection fees will be paid by the parties above.

Reminder System:

Our medical practice provides our patients with preventative care and early reminders, for example: Immunization, Annual Health Checks and Pap Smears.

Do you wish to have any relevant health reminders sent to you? **YES / NO**
If you wish not to please notify the reception staff to take note onto your personal file.

If we need to contact, you what is your preferred method? (Please circle below)

Home Phone **Mobile** **Mail** **SMS**

Patient's Signature:		**DATE:**

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To stay up to date, scan the QR code above or visit www.facebook.com/Hamilton-Family-Practice-205258006683043/

Please tell us how you have heard / known about us: *Friend* ☐ *Flyer* ☐ *News Paper* ☐
Social Media ☐ *Radio* ☐ *Drive Past* ☐