BHRMC
BELGRAVE-HALLAM RD MEDICAL CENTRE

Patient Registration Form

PLEASE COMPLETE IN **BLOCK CAPITAL** LETTERING

please circle

MR MAST MRS MS MISS DR **DATE OF BIRTH:**_ _/_ _/_ _ _ _

First name: _____ Surname: _____

Address: _____ Suburb: _____ Postcode: _ _ _ _

Contact Details: Mob: _____ Home: _____ Work: _____

E-Mail address : _____

Emergency contact:
Name: _____ Relation: _____ Contact Number: _____

Next of Kin: Name: _____ Relation: _____ Contact Number: _____

Billing Details

Medicare Card: _____ Ref: ___ Expiry: _ _/_ _ _ _

Please Circle

Concession Card: _____ Expiry: _ _/_ _/_ _ _ _ Type: Health Care / Pension

Medical History

Aboriginal/Torres strait Islander? YES NO

Country of birth: _____ Cultural Background_____

Primary Language: _____ Do you require an Interpreter?: YES NO

Do you need a ramp or disabled facilities? YES NO Are you Vision or Hearing impaired? YES NO

Smoking: YES, How many a day? _____ EX-Smoker, When did you quit? _____ NO/NEVER

Alcohol: Days per week? _____ Number per day? _____ NO/NEVER

In order for you and your doctor to work together to achieve the best possible health outcomes, it is important that the doctor understands you as more than just a patient with an illness.

PRINT NAME) _____, (DATE) ___/___/____ consent to this practice transferring this information to other Health Providers for the purpose of my ongoing medical management, or for use in Practice Enhancement Activities (information will be deidentified wherever possible when used for Practice Enhancement). Signature_____

Turn page over for consent form.

156, Belgrave Hallam Rd, Narre Warren North VIC 3804 Tel:03 8842 4499 Fax:03 8842 4490 Web: www.bhrmc.com.au ABN:31516026934

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PATIENT HEALTH INFORMATION CONSENT FORM

The practice requires your consent to collect personal information about you.
Please read this information carefully, and sign where indicated below.

This Medical Practice 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. Please place a tick in the boxes if you consent for your information to be used in the following ways:

☐ I give permission for my personal health information to be used for administrative purposes to assist in the running of Belgrave Hallam Road Medical Centre including, disclosure to others involved in your healthcare, such as treating doctors and specialists within and outside the Medical Practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

☐ I give 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 consent to the presence of a third party to be present during my consultation. This may include Practice Nurse, Medical or University Student.

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

☐ I give consent to submit data to various disease registers (cervical, breast and bowel screening etc) for preventative health.

☐ I give consent to be contacted via mobile for recall/reminders and appointment confirmation.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a Privacy Policy on handling Patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the Health Care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand 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 above, my further consent will be obtained and I am free to withdraw my consent at anyone time by verbal or written notification.

Signed: ..... Date: __/__/____

Patient Name: ..... (Printed)