

NEW PATIENT REGISTRATION FORM

Please complete **all** parts of the form clearly

TITLE: <i>please circle</i>	MR MRS MS MISS MAST	SURNAME:	_____
PRONOUNS: <i>please circle</i>	She/Her/hers He/Him/His They/Them/Their	MIDDLE NAME:	_____
FIRST NAME/S:	_____	DATE OF BIRTH:	_____
PREFERRED NAME:	_____	BIRTH SEX: M / F	_____
ADDRESS:	_____		
SUBURB:	_____	POST CODE:	_____
HOME PHONE:	_____	MOBILE PHONE:	_____
ETHNICITY/ COUNTRY	<input type="checkbox"/> AUSTRALIAN	<input type="checkbox"/> ABORIGINAL	
OF ORIGIN: <i>please tick</i>	<input type="checkbox"/> OTHER (please specify) _____	<input type="checkbox"/> TORRES STRAIT ISLANDER	
OCCUPATION:	_____		

MEDICARE AND CONCESSION CARD

CARD #

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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REF # (the number appearing before your name on the card)

EXPIRY DATE ____/____/____

CONCESSION CARD HOLDERS

CARD NUMBER _____

☐ PENSIONER CONCESSION

☐ HEALTH CARE CARD

EXPIRY DATE ____/____/____

☐ SENIORS HEALTH CARD

Please tick

DVA CARD HOLDERS

CARD NUMBER _____

☐ GOLD

☐ WHITE

Please tick

NEXT OF KIN

FULL NAME:	_____	RELATIONSHIP:	_____
CONTACT NUMBER:	_____	ADDRESS:	_____
SUBURB:	_____	POST CODE:	_____

EMERGENCY CONTACT (different to above)

FULL NAME:	_____	RELATIONSHIP:	_____
CONTACT NUMBER:	_____	ADDRESS:	_____
SUBURB:	_____	POST CODE:	_____

CONSENT DECLARATION (Please read and tick the boxes)

☐ I declare that I have answered the above questions correctly and to the best of my knowledge.

I understand that CORFIELD DOCTORS SURGERY complies with the privacy act (1998) and are committed to protecting my personal health information.

☐ I understand that I have the right to request access to my information except where access would be denied, and that CORFIELD DOCTORS SURGERY makes every effort to manage my information in accordance with the national privacy principals and keeps my records up to date.

I understand I may withdraw my consent for CORFIELD DOCTORS SURGERY to use and disclose my personal information following a discussion with the doctor (except when legal obligations must be met).

☐ I consent to CORFIELD DOCTORS SURGERY collecting, using, storing and disposing of my personal information and releasing relevant information to other Health Professionals for the purpose of quality medical care.

☐ I consent to inclusion on the CORFIELD DOCTORS SURGERY recall reminder system. I accept that I may receive correspondence from the practice by either phone call, text message or mail, for follow up visits that have been requested by the doctor, appointment reminders, medical updates and health information from the practice.

☐ I understand that all accounts must be paid at the time of consultation and that I am responsible for payment of any children under the age of 16, without a valid Medicare card, if I am their parent or guardian.

☐ I have received the CORFIELD DOCTORS SURGERY information leaflet.

☐ I acknowledge that CORFIELD DOCTORS SURGERY has a late or no-cancellation fee.

☐ I acknowledge that CORFIELD DOCTORS SURGERY is a bulk-billed practice, however certain procedures are not covered by Medicare and will incur a small fee.

EMAIL: _____

PATIENT OR PARENT/
GUARDIAN SIGNATURE: _____

DATE: _____

HOW DID YOU HEAR ABOUT US?

COMPLAINTS

The Health and Disability Services Complaints Office (HADSCO)

1800 813 583

<https://www.hadsko.wa.gov.au/>