Patient Registration

Personal Details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other:

First Name

Surname

Preferred Name

Date of Birth

Gender Female / Male / Other

Nationality

Are you ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Address

Suburb

Postcode

Mobile Phone

Home Phone

SMS Reminders *Appointment reminders* ☐ Yes ☐ No *Clinical reminders* ☐ Yes ☐ No

Email Address

Occupation

Healthcare Information

Medicare Card # Reference: Expiry:

Concession Card # Card Type: ☐ HCC ☐ Pensioner ☐ Seniors Expiry:

DVA Card # Card Type: ☐ Gold ☐ White Expiry:

Emergency Contact

Name

Phone Number

Relationship

Next of Kin

Name

Phone Number

Relationship

Feedback

How did you hear about us?

☐ Word of mouth ☐ Walk/drive by ☐ Internet ☐ Other_____

Patient Consent

I understand that Doctors of South Melbourne is committed to protecting the privacy of individuals and their personal information in accordance with the Privacy Act 1988. My signature below indicates that I consent to Doctors of South Melbourne collecting, using, disclosing, storing and disposing of my personal information for the purposes set out in Doctors of South Melbourne's Privacy Policy. This includes, but is not limited to: information to enable me to be attended to by medical practitioners to provide medical services and treatment, the release of relevant personal information to doctors and employees of the clinic and other health professionals to allow quality medical care and administration purposes, and inclusion in a recall register to be advised of follow up visits, medical updates and health information. I understand I may withdraw my consent for Doctors of South Melbourne to use and disclose my personal information (except when legal obligations must be met).

I also understand, and consent to, Doctors of South Melbourne's cancellation policy. Cancellation requires at least 2 hours' notice if I am unable to attend an appointment. I understand that I may be charged a cancellation fee (full consultation fee) as a result of multiple non-attendances or failing to give enough notice.

Patient Signature_____ Date _____