Sonic HealthPlus

New Patient Registration – GP COVID Clinic

PERSONAL DETAILS

Title: ☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Other: _____

Surname: _____ Given Name: _____

Middle: _____ Preferred Name: _____

DOB: D D M M Y Y Y Y Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other: _____

Medicare: _____ Ref: _____ Exp D D M M Y Y

Vet Affairs Number: _____ ☐ Gold ☐ Orange ☐ White Exp D D M M Y Y

KNOWING YOUR CULTURAL BACKGROUND CAN HELP US PROVIDE INDIVIDUALISED HEALTHCARE

Please tick the box which applies to your cultural background:

☐ Australian: Non-Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

ADDRESS AND CONTACT INFORMATION

Street Address: _____

Suburb: _____ State: _____ Postcode: _____

Postal Address (if different from above): _____

Telephone (H): _____ (W): _____ (M): _____

Email Address : _____

NEXT OF KIN / EMERGENCY CONTACT

Name: _____ Relationship: _____

Street Address: _____

Telephone (H): _____ (W): _____ (M): _____

ABOUT YOU

Is English your first language? ☐ Yes ☐ No

If not, do you need an interpreter? ☐ Yes ☐ No

Language: _____

MANAGEMENT OF PATIENT HEALTH INFORMATION

This medical centre collects information from you for the primary purpose of providing quality health care.

We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in your health care. We will also collect, hold, use and disclose the information you provide in accordance with Sonic HealthPlus Privacy Policy (the "Centre's Privacy Policy"). A copy of the Centre's Privacy Policy is available at the Centre's reception or can be obtained at (website https://www.sonichealthplus.com.au/clients/privacy-policy).

The Centre may collect, hold, use or disclose your personal information for purposes including, but not limited to:

- Patient Satisfaction Surveys;
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements;
- To update our records and keep your contact details up to date;
- To communicate with you regarding appointment reminders, recalls, and services which may be of interest to you;
- Health service promotions including important health messages;
- Disclosure to others involved in your health care, including treating doctors and specialists outside of this medical practice;
- De-identified for research and quality assurance activities to improve individual and community health care and practice management.

CONTACTING YOU

I consent to receive the following electronic reminders/voice messages:

☐ Appointments ☐ Clinical Communication (results and messages) ☐ Clinical Reminders ☐ Health Awareness ☐ I do not want to receive messages

I acknowledge that I may be contacted using any of the contact details I have provided.

PLEASE SIGN HERE

I consent to my personal information being collected, held, used and disclosed in accordance with the Centre's Privacy Policy.

Signature: _____ Date D D M M Y Y

THANK YOU

OFFICE USE ONLY (please tick) - Staff please ensure you have sighted at least 1 of the ID Cards below:

Identification Sighted: Photo ID ☐ Medicare Card ☐ Concession Card ☐

Employee Name and Signature: _____