Medical Hub@RMIT

Patient Registration Form

Title		**Gender**	
First name		**Preferred name**	
Family name/ Surname			
Address			
Date of Birth		**Telephone**	**Mobile**
			Home
			Work
Email			
Occupation		**Current RMIT:**	**Student / Staff (please circle)** Please show your RMIT card to reception at each appointment
Ethnicity		**Language other than English**	
Next of Kin/Emergency Contact			
First Name:		Surname:	
Phone No		Relationship:	

To assist with health initiatives, are you Aboriginal or Torres Strait Islander?
□Aboriginal □Torres Strait Islander □Aboriginal & Torres Strait Islander □No

Do you authorise the practice to send you SMS appointment confirmations?
YES / NO

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and Pap smears
□ Do you wish to have any relevant reminders sent to you? YES / NO

Billing information (please provide relevant card/s to reception with this form)
□ Medicare card
□ Concession card (health care card or Pension card)
□ Department of Veteran Affairs cards
□Private Health Fund details: Medibank / Allianz / Bupa / NIB / HCF

Alcohol Use

Current alcohol intake Do you drink alcohol? Days per week?	YES / NO _____	Past Alcohol intake: □ Nil □ Occasional □ Moderate □ Heavy Year Started: _____ Year Stopped: _____

Smoking History
□ Non-Smoker □ Ex Smoker □ Smoker Year started: _____

Weight: _____ Height: _____

Medical Hub@RMIT

Your Health Information

To enable ongoing care and total quality improvement within this practice and in keeping with the Privacy Act (1988) and the National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.
Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.
The information we collected may be collected by a number of different methods and examples may include: medical test results, notes form consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).
By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- follow up reminder/recall notices for treatment and preventive healthcare;
- for accounting procedures and the collection of professional fees;
- the diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided;
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GPs and - other professionally trained and qualified persons, e.g. General Practice Managers;
- For legal related disclosures as required by Court of Law;
- For the purposes of research where de-identified information is used;
- To allow medical students and staff to participate in medical training/teaching using only de-identified information;
- For disease notification as required by law;
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Cancellation Policy
We understand that at times circumstances arise and you may not be able to keep a scheduled appointment. We request that you provider a minimum of 2 hours notice to cancel or reschedule an appointment to avoid a $20 cancellation fee.

I, _____, give my permission for my personal health information to be collected, used and disclosed above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter to restrict my consent at any time by notifying this practice in writing.

I have read and understood the Medical Hub's cancellation policy.

Signature: _____ Date: _____

If not the Patient signing – Your name (please print): _____