Windmill PRACTICE

New Patient Registration and Consent Form:

Title: **Surname:** **First Name/s:**

Preferred Name: **Gender:** **DOB:**

Residential Address:

Postal Address (if different):

Email Address:

Home Phone: Work Phone: **Mobile Phone**:

Cultural Identity: Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Country of birth: **Country of origin:**

Medicare and Health Membership Details

Medicare number and reference: Expiry date:

DVA, Pension, Health Care Card and/or Private Health Fund: *(number and expiry)*

Occupation: **Current employer:**

Allergies: **Nil known allergies** ☐

Current smoker ☐ **Ex-smoker** ☐ **Never smoked** ☐

Next of kin:

Name: Contact Phone: Relationship:

Alternate Alternate emergency contact: *(if we can't contact you or next of kin)*

Name: Contact Phone: Relationship:

Privacy and communication Consent

Do you consent to receiving SMS reminders for appointments? Yes ☐ No ☐

Would you like to enrol to use the Best Health App? Yes ☐ No ☐

Do you consent to receiving clinical communication via the app or SMS? *(eg: results)* Yes ☐ No ☐

Do you consent to receiving clinical reminders via the app or SMS? *(eg: tests, referral due)* Yes ☐ No ☐

Do you consent to personal information being collected and used to create your electronic health record at Windmill Practice? *(essential for registration)* Yes ☐ No ☐

This completed registration and request for transfer of Medical Records forms must be completed prior to booking initial appointment.
Please advise the office if unable to attend an appointment.
Failure to attend or cancelling with less than 2 hours notice will incur a $40 fee which must be paid before another appointment is booked.
I agree to the above conditions and request to be registered as a patient at Windmill Practice.

Patient/carer's Signature: **Date:**

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