Windmill PRACTICE

2024 - New Patient Registration and Consent Form:

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

Preferred Name: **Gender:** **Pronouns:** **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

What race/ethnicity best describes you: **Country of birth:**

Healthcare Identifiers

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

Name: Contact Phone: Relationship:

Privacy and communication Consent

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

Do you consent to receiving SMS/HotDocs clinical messages and reminders? *(eg: results, tests due)* Yes ☐ No ☐

Do you consent to your information being shared with others involved in your healthcare, including specialists, allied health and investigation service providers? *(eg: for referrals and care plans)* Yes ☐ No ☐

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

Do you consent to new information being uploaded to your My Health Record? Yes ☐ No ☐

Your details are treated with the utmost confidentiality – for further information – please see our privacy policy – displayed in the reception area or ask our staff.
This completed registration and request for transfer of Medical Records forms must be completed prior to booking an initial appointment.
Please advise the office 24 hours prior if unable to attend an appointment or you 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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