KINGSCLIFF BEACH MEDICAL

40 Marine Parade
Kingscliff NSW 2487
Phone 0266743266 Fax 02 6674 3200

Patient Registration Form

Title ___________ Surname _________________________ Given Names ____

Known As: ______________________ Date of birth _____/_____/______ Gender ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed

Medicare No. ________________________________ Number in front of name _______ Expiry Date ____________________

Centrelink Pension ☐, Centrelink Health Care Card ☐ or Veterans Affairs ☐ Number (if applicable) ________________

Expiry Date_____________________

Occupation _______________________________________

Address ____

Suburb ____State ___________________________ Postcode _____________

Phone (home) _________________________ (work) _________________________ Mobile __________________________

Emergency Contact

Name ____ Relationship to you ____________________________

Phone (home) ________________________________ Mobile __________________________________

Next of Kin (if different to above)

Name ____ Relationship to you ____________________________

Phone (home) _______________________________ Mobile _________________________________

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please elaborate ____

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as immunisations, pap smears and other health reviews.

I consent to being contacted with reminders ☐ Yes ☐ No

In completing this form I understand that my personal information is been collected and consent this information to be shared when relevant and appropriate to my treatment. A full copy of our Privacy Policy and Health Information Collection Policy can be obtained from reception

Our practice follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws.

Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

Signature of patient or guardian _______________________________________ Date _____ / ______/ ______

Please Note we only Bulk Bill current Centrelink pension card holders, DVA Gold Card Holders & children under 16 years of age