temple hills medical centre
2 Devlaw Drive, Doncaster East, 3109
Telephone: 9842 9911 (All Hours) Fax: 9842 9916
Website: www.templehillsmedical.com.au
PAECAA Pty Ltd ABN 69 234 235 648

NEW PATIENT REGISTRATION FORM

(Please ensure that you complete all sections of this form and hand back to receptionist ASAP)

Title: …………………**Given Name**:………………………………… **Surname**:……………………………………………………………

Sex: Male / Female

Date of Birth: / /

Patient Address:……………………………………………………..

……………………………………………………………………………

……………………………………………………………………………

Telephone No:………………………………………………………..…

Mobile No:…………………………………Receive SMS: Yes / No

Marital Status:…………………………………………………………

Occupation:……………………………………………………………

Country of Birth:………………………………………………………

Cultural Background:…………………………………………………

Medicare No:……………………………………………………

Patient No: ☐

Expiry Date:……./……….

Health Care Card No:…………………………………………..

Expiry Date:……../………..

Pensioner Concession Card No:………………………………

Expiry Date:……../………..

Veteran Affairs No:………………………………………………..

Next of Kin:……………………………………………………………

Relationship of next of kin:……………………………………….

Next of Kin Phone No:…………………………………………………

Emergency Contact (if different from next of kin):

…………………………………………………………………………...

Emergency Contact Phone No: ……………………………...

Are you Aboriginal or Torres Strait Islander: Yes / No

If yes, please indicate whether you are:

☐ Aboriginal ☐ Torres Strait Islander

☐ Aboriginal & Torres Strait Islander

For children under 16

Parent / Guardian Name:…………………………………………..

Date of Birth of Parent / Guardian / /

Address:…………………………………………………………………...

Medicare No:……………………………………………………………...

How did you hear about Temple Hills Medical Centre?

☐ Personal Recommendation ☐ Social media ☐ Google ☐ Live near by

☐ Other – please state ____

Payment is required at time of consultation

We accept Cash, Cheque, EFTPOS & Credit card. ***Amex and Diners not accepted***

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PATIENT CONSENT FORM

Temple Hills Medical Centre requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes, and sign where indicated below.

This Medical Practice collects information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

☐ I give my permission for my personal health information to be used for administrative purposes to assist in the running of Temple Hills Medical Centre, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. (This may occur through referrals to other doctors and specialists, or for medical tests and in the reports or results returned to my doctor following referrals.)

☐ I give my consent for disclosure for research and quality assurance activities to improve individual, community health care and Practice management. (This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.)

☐ I give my consent for my personal health records to be used for identifiable patient health information. (This may occur when the Practice participates in research activities on behalf of a university as part of professional development activities. Identifiable patient information can possibly be traced back to the individual.)

☐ I give my consent to the presence of a third party to be present during my consultation. (This may include a Practice Nurse or medical student.)

☐ I give my consent to be part of the Practice’s National, State and Territory recall and reminder systems.

I understand that by ticking the relevant boxes above that the Practice is authorized on my behalf to use my personal health information and I am free to withdraw my consent at any time by verbal or written notification.

Name of Patient:……………………………………………………………………………………………

Signature of Patient:………………………………………………………………………………………

Print name and signature of Parent / Guardian (if patient under 18):………………………………….

Date:……………………………….