Vineyard Medical Centre
2-6 Sussex Court, Sunbury, 3429
Ph: (03) 9216 5600 Fx: (03) 9216 5699
www.vineyardmedicalcentre.com.au

New Patient Registration Form

Contact Information		
Title:		
Surname:		
First Name:		
Date of Birth:		
Gender Identity:		Pronoun: she/her, he/him, they/them
Street Address:		
Postal Address: *(if different to above)*		
Home Phone:		
Work Phone:		
Mobile Phone:		
Email:		

Cultural Background			
To assist with health initiatives and being able to provide the best care to you – are you Aboriginal and/or Torres Strait Islander? ◯ No ◯Yes – Aboriginal ◯ Yes – Torres Straight Islander ◯ Yes - Both			
Country of birth		Language Spoken	
Do you require an interpreter: ◯ No ◯ Yes *please circle* Interpreter or Auslan			

Emergency Contact Details	
Name:	Relationship to you:
Home Phone:	Mobile Phone:

Next of Kin	
Name:	Relationship to you:
Home Phone:	Mobile Phone:

Healthcare Identifiers		
Medicare Number:	Ref:	Expiry: /
DVA Number:		◯ Gold ◯ White
Pension/Health Care Card Number:		Expiry: /

Health Information
Do you have any known allergies: ◯ No ◯ Yes – provide details or what you are allergic to and you reaction please
Are you currently taking any medications: ◯ No ◯ Yes – provide details
Height: Weight:
Do you: Smoke Yes/No Drink Alcohol Yes/No

Full payment is required on the day of service

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Patient Consent

Please read this consent form carefully prior to signing.
This general practice collects information from you 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 and treat illnesses and medical conditions, ensuring we are proactive in your health care. To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with sufficient information on how your personal information may be used or disclosed and record your consent or restrictions to this consent.

Your personal 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 information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare 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/parent/guardian) are consenting to the collection of your personal information, and that it may be used or disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Billing purposes, including compliance with Medicare requirements.
- Follow-up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS and/or email.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual and community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- 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.

Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

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Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information.

By signing this document below, I agree to the following

* I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
* I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
* I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
* I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
* By completing the section below and providing a signature, I consent to the handling of my information by this practice for the purposes set out above, subject to any limitation on access of disclosure that I notify the practice of.
* I consent or decline as indicated to receive an SMS and/or Email message regarding future appointments and/or medical recalls and reminders.

access of disclosure that I notify the practice of.

* I consent or decline as indicated for my practitioner to take photos that may be necessary to assist in my treatment or diagnosis.
* I consent as indicated to messages being left on telephone message service
* I understand payment is required on the date of service and will incur a $10 admin fee if I am unable to. *"In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs".*

SMS and photos consent – please tick below
Consent ☐ Decline ☐
Patient name: (please print)

_____

Signature: _____ Date: _____

If not patient signing - your name (please print)

_____
Your relationship to patient (e.g. Mother, Father, guardian, medical POA)

_____

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Practice Communication Consent

The purpose of this form is to inform you and seek your consent to the use and disclosure of your personal information (including health information) in regards to our reminders and notifications systems within our practice.

This general practice is committed to providing our patients with quality health care. As part of our commitment, we have implemented technology solutions to enable communications with our patients via SMS and mobile applications.

In keeping with our obligations under Privacy Act 1988 (Cth) and Australian Privacy Principles and under State and Territory health records legislation, we wish to inform you of the purposes for which we may use your personal information and how we may use and disclose your personal information (including health information). Please refer to our privacy policy or privacy statement https://www.vineyardmedicalcentre.com.au/copy-of-availability for more information generally on the management of personal information (including health information) by this general practice.

In addition to other communications we may send you from time to time, we may send you the following types of communications:

1. ***appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
2. ***clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
3. ***clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*
4. ***health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*

As part of the provision of health care services to you, we will send you appointment reminders, clinical reminders and clinical communications from time to time. We may also send you health awareness information if you have consented to receive such communications below. We may use third party service providers (which may be located outside of this State or Territory) and disclose your personal information (including health information) to them, to assist us in sending you the above communications.

Acknowledgements and Consent

I acknowledge and agree that, in the course of providing health care services to me, the general practice may need to use and disclose my personal information (including any health information) as set out in this form.

I wish to receive health awareness communications (as described above) and I hereby specifically consent to the use of my personal information (including any health information) by this general practice to assess the types of health awareness communication it sends me and specifically consent to receipt of such health awareness communications. ☐

This patient consents to receive electronic reminders/messages, as outline above (SMS, App &/or email)

I acknowledge that the practice will use contact details provided by me (as updated by me from time to time) to communicate with me. To the extent that the mobile number I have provided to this general practice is utilised by more than one patient, I understand and consent that all SMS and phone communications will be directed to that number.

Please complete and sign below if you understand and agree to the acknowledgements and consent set out above.

Patient Name: _____

Parent/Guardian Name (if Patient is under 16) _____

Signature: _____ Date: _____