NORTH RYDE
MEDICAL CENTRE

New Patient Registration Form

Title Mr Mrs Ms Miss Master Dr Other:_____	**Date of Birth** / /	**Gender** □ M □ F

Surname	**Given name(s)**	**Occupation**

Address	**State**	**Postcode**

Phone (mobile)	**Phone (home)** ( )	**Phone (work)** ( )

Medicare number	**Line Ref no.**	**Expiry**	**Email**
_ _ _ _ _ _ _ _ _ _	_	_ _ / _ _ _ _	

Do you have a Commonwealth/Centrelink Concession card?
(if yes, you may be eligible for our concession fee rates)

□ No

□ Pensioner concession card
□ Health Care Card
□ Commonwealth Seniors Health Card
□ DVA Veterans Card:
□ Gold □ White

Concession Card no.:

_____

Expiry _ _ / _ _ / _ _ _ _

Ethnicity

□ Aboriginal
□ Torres Strait Islander
□ Aboriginal and Torres Strait Islander
□ Australian, non-indigenous
□ Other ……

Emergency contact details	**Next of Kin contact details (if different)**
Name: Phone: Relationship:	Name: Phone: Relationship:

Your Medical History

Medical Conditions (past or present conditions, surgeries etc.)	**Regular Medications**	**Family History**
		Alcohol □ None or Less than once per week □ More than once per week: Days per week: _____ Std drinks on those days: _____
	Allergies	**Smoking** □ No □ Yes: How many cigs per day? ___

Our Practice Privacy Policy

North Ryde Medical Centre is committed to providing quality health care for its patients and is bound by the National Privacy Principles. In providing medical care to you, it is necessary for us to maintain files pertaining to your health. Your medical file is handled with the utmost respect for your privacy, and will be accessed by our doctors/nurses as required for your care. Our staff will be required to handle your file for administrative purposes. All staff are bound by strict confidentiality requirements as a condition of employment and these requirements will always be observed in relation to your medical record and personal information. If you would like to read our full privacy policy, please ask one of our receptionists to print a copy for you.

Reminders and Registers

Reminders & Recalls: Our practice uses a Secure SMS Reminders & Recall system to remind you about appointments and contact you (if required) about clinical test results/reminders related to your health.
If required, we may attempt to contact you by email if we cannot establish contact with you by phone/SMS.
(Please advise the practice manager if you wish to opt-out of the SMS Reminder & Recall system)

Registers: Our practice participates in State and National registers for tests eg. National Cervical Screening Register
(Please advise the doctor at the time of the test if you wish to opt-out of the relevant State or National Register)

Health Information Collection and Use - Consent

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

North Ryde Medical Centre 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 be pro-active in your health care. We will also use the information you provide in the following ways:

- *Administrative and Billing purposes in running our medical practice, including compliance with Medicare and Health Insurance Commission requirements*
- *Disclosure to others directly involved in your health care, including treating doctors and specialists inside or outside this medical practice. This may occur through referral to other doctors (with your consent), or for medical tests and in the reports or results returned to us following the referrals*
- *To comply with any legislative or regulatory requirements eg. notifiable diseases*
- *Disclosure of non-identifiable information for quality improvement activities to improve patient and community health outcomes and practice management. For example, non-identifiable information may be sent to the local primary health care network as a requirement of the Australian Government's Quality Improvement PIP program. (However if you do not wish to participate, please discuss with the practice manager* □**)**

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√ 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 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 I request access to information about me, the practice will be entitled to charge me fees deemed to be reasonable.
√ 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.
√ I consent to the handling of my information by this practice for the purposes set out above

Name …… **Signed** ..... **Date** ……./……./……..