Wollongong Medical
Specialists

Shellharbour Medical
Specialists

We need this information to provide the best quality care. This form complies with the AMA standards. This means your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your specialist. Please notify us promptly of any changes in your contact details.

New patient registration form

Section A: **Personal details**

Title Surname Given names

Date of birth (dd/mm/yy) Gender Marital status (Single Married Defacto Divorced Widowed)

Home address

Postal address

Mobile Number **Home Number** **Work number**

Email

Medicare card number Medicare reference number Medicare card expiry date

Pension, Health Care Card or Veterans Affairs number (if applicable) Type of Veterans Affairs card Expiry

Private Health Fund

Company **Membership Number** Expiry

Occupation

Who can we contact in an emergency?

Name | **Relationship to you**

Mobile Number | **Home Number** | **Work number**

Section B: **Cultural background**

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

Are you registered for CTG PBS Co-Payment relief ☐

Other cultural background (eg Mediterranean, Asian, African) | **Country of birth**

Section C: **Allergies and medicines**

List allergies and intolerances to medications

List regular medications and doses, and complementary medicines and doses

Section D: **Referring Details**

Name and address of referring Doctor

Name and address of usual General Practitioner (GP)

PRIVACY AGREEMENT / CONSENT FORM

I, ______________________ **D.O.B.** __________

of ______________________

hereby give permission for my doctor at **Wollongong Medical Specialists** and **Shellharbour Medial Specialists** to access any results, medical information and/or correspondence essential for my health management.

I also give permission for my doctor to release my medical information to my referring doctor and/or treating doctor for my ongoing care, investigations, and management unless I instruct the practice otherwise. This may be required for:

1. Administrative purposes in creating a confidential file.

2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.

3. 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.

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 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 Wollongong Medical Specialists for the purposes set out above, subject to any limitations or disclosure of which I may notify Wollongong Medical Specialists.

I am aware that Wollongong Medical Specialists regards my privacy as a paramount concern and that in day to day working, my doctor may have access to my medical records. I understand that he will regard these records with a view to maintaining my privacy in line with all relevant legislation.

Signed: ______________________ **Date:** __________

Section D: **Consent**

I consent to being contacted with reminders to help me maintain my health

Yes ☐ No ☐

This practice uses My Health Record. I wish to opt in

Yes ☐ No ☐