



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:**

Address:

Date of birth: **Gender:** **Marital Status:**

Ph: (h) **(m)** **(w)**

Email

Medicare Number: **Ref:** **Exp:**

Pension, Healthcare Card or Veterans Affairs number: **Exp:**

Health Fund: **Membership Number:**

Who can we contact in an emergency:

Name: Relationship to you:

Best contact Number:

Section B: **Cultural background** *Knowing your cultural background can help us provide healthcare that meets your needs*

Are you of Aboriginal or Torres Strait Islander Origin?

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

Section C: **Allergies and Medications**

List of allergies and intolerances to medications

List regular medications and doses

Section D: **Referring Details**

Name of referring doctor

Name and suburb 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 Medical 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.
4. The practice uses de-identified (personal information is removed) images for accreditation purposes, learning and educational purposes if you wish to not have your de-identified images used, please advise the reception staff.

I consent to the use of AI letter generation and documentation in my electronic file.

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

I am aware that Wollongong Medical Specialists and Shellharbour 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.

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

yes no

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

yes no

Signed:

Date: