MJD Health Medical Clinics

NEW PATIENT REGISTRATION FORM

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other ☐

Single ☐ De-facto relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

First Name _____ Middle Name _____ Surname_____

Date of Birth: _____/_____/_____ **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Other

Medicare Number ☐☐☐☐☐☐☐☐☐☐ Ref ☐ Expiry ___ /____

Concession Card ☐☐☐☐☐☐☐☐☐☐ HCC☐ PEN☐ Expiry ___ /___

DVA Card No: _____ Gold / White: _____ Expiry ___ /____

Home Address: _____

Suburb: _____ **Post Code** _____

Mobile No _____ **Home No** _____ **Work No** _____

Email address_____ **Occupation**_____

Private Health Insurance: No ☐ Yes ☐ Type of Cover: Top ☐ Intermediate ☐ Basic☐

Do you identify as Aboriginal ☐ Torres Strait Islander ☐ or both and ☐

Country of Birth _____Year arrived in Australia if born overseas _____

Cultural Background (Family Heritage) _____

Is English your primary language ☐ Yes ☐ No

Other languages spoken _____ is an interpreter required ☐ Yes ☐ No

Next of **KIN** Contact Details Mr, Mrs, Miss, Ms

First Name _____ Surname _____ Relationship _____

Contact No _____

EMERGENCY Contact Details Mr, Mrs, Miss, Ms

First Name _____Surname _____ Relationship _____

Contact No _____

Reminders

For your convenience, we now provide SMS appointment reminders and many preventative health reminders. A reminder will be sent via SMS to your mobile phone before your appointment, confirming the date and time of your booking. In the event that your circumstances have changed, please ring us immediately to advise us that you are unable to attend at this time. You are able to opt in or out at any given time.

	I Consent		**I Do Not consent**	To my mobile number being used for the purpose of SMS reminders at this practice.

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail, telephone or sms for procedures such as vaccinations; pap tests and other health reviews for continuity of your health care. This practice participates in the National/State/Territory reminder systems.

	I Consent		**I Do Not consent**	To my details being used for the purpose of reminders at this practice.

My Health Record

	I Consent		**I Do Not consent**	To my health record being viewed as a part of the quality improvement activities at this practice**. Do Not** complete below
	I Require		**I Do Not Require**	Help to register for a My Health Record account. **Complete** below.

Research

Our practice undertakes research, professional development and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose, have signed written a confidentially agreement and all information is de-identified for your privacy.

	I Consent		**I Do Not consent**	To my details, being used for the purpose of research, professional development, quality assurance and improvement activities at this practice.

Print Name _____ **Signature** _____ **Date** ____/_____/2016

This practice is committed to ensuring the privacy and confidentiality of all personal information affiliated with MJD Health Medical Clinics if you wish to review this policy please ask at reception.

My Health Record

The Chief Executive Medicare may hold information about you, which can be included in your My Health Record over time.

This information may include details that indicate diagnosed conditions and illnesses. If you do not want to have such details visible in your My Health Record, you should not consent to the inclusion of this information.

You can withdraw your consent at any time, in which case no new information will be provided to the System Operator for inclusion in your My Health Record. Importantly, however, if an item of information was indexed in your My Health Record before you revoke your consent, the full item may be made available to the System Operator at any time, even after you revoke your consent.

	I Consent		**I Do Not consent**	To my health record being viewed as a part of the quality improvement activities at this practice**. Do Not** complete below
	I Require		**I Do Not Require**	Help to register for a My Health Record account. **Complete** below.

Please indicate which information, if any, you consent to being included in your My Health Record:

	Details of all future claims made for Medicare benefits whenever you receive a healthcare service that is covered under the Medicare Benefits Schedule (MBS)*
	AND details of any past claims for Medicare benefits, if available* (This option is only available if you have selected 'all claims' above.)
	Details of all future claims made for Pharmaceutical benefits whenever you receive medication that is covered under the Pharmaceutical Benefits Scheme (PBS)**
	AND details of any past claims for Pharmaceutical benefits, if available** (This option is only available if you have selec future claims' above.)
	Your organ and/or tissue donation decision(s), which are sourced from the Australian Organ Donor Register (AODR)
	Details of the immunisations administered to you up until the age of 7, which are sourced from the Australian Childhood Immunisation Register (ACIR)

Note:

* this includes claims that are processed by the Department of Human Services on behalf of the Department of Veterans' Affairs (DVA), in accordance with eligibility entitlements provided by DVA. Information is only included where the claim for a benefit has been successful.

** this includes Department of Veterans' Affairs claims under the Repatriation Pharmaceutical Benefits Scheme (RPBS) that are processed by the Department of Human Services. Information is only included where the claim for a benefit has been successful.

For further information on the specific types of information that are included in your My Health Record refer to the www.myhealthrecord.gov.au website.

Print Name _____ **Date** ____/_____/_____

Signature _____

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