saratoga medical

NEW PATIENT REGISTRATION

Title: _____ **Surname**: _____

Given name: _____

Middle name: _____

Preferred name: _____

Date of birth: _____ Sex: **M F**

Nationality: _____

Address: _____

Suburb: _____

Postcode: _____

Home phone: _____

Work phone: _____

Mobile: _____

Email: _____

Occupation: _____

Consent to SMS: ☐ Aboriginal: YES ☐ NO ☐

Torres Strait Islander: YES ☐ NO ☐

Medicare No: _____ **Ref**: __

Expiry Date: _____

Pension No: _____

Expiry Date: _____

Health Care Card: _____

Expiry Date: _____

DVA No: _____

White or Gold Card (Please circle)

Private Fund Name: _____

Fund Number: _____

Next of Kin: _____

Phone: _____

Relationship: _____

Emergency: _____

Phone: _____

Relationship: _____

Name/Address/Phone no. of previous GP: _____

List any Significant Medical Conditions: _____

List any allergies**:** _____

Please list all current medications (including over the counter, herbal or other preparations, as well as prescribed).

_____

_____

Past operations (if any):_____

_____

Smoking status: please circle one: Smoker / Ex-smoker / Non-smoker

Family history of illness (e.g. heart; BP; diabetes; stroke; arthritis; asthma; depression; other)

Mother: _____ Father: _____

Siblings: _____ Grandparents: _____

Last Tetanus injection: _____

We are interested to know how you heard about this surgery.

Referral from another patient ☐ Referral from other doctor ☐ other _____

PHOTO ID PROVIDED & SCANNED YES ☐ NO ☐

Consent

Please read the information on this form carefully. You are under no obligation to provide consent to the use of your personal information. If you do not consent, we will respect your decision.

Please circle your answer and sign below.

- I give consent for the staff and doctors of Saratoga Medical to contact me on:
  Home phone…….. YES ☐ NO ☐
  Mobile phone…… YES ☐ NO ☐
  If necessary, leave a message on an answering machine (if I am unavailable) …… YES ☐ NO ☐

- I understand that the doctors and staff may have to provide details of my ongoing care to third parties such as other healthcare providers (i.e. specialist, pathology). I understand the Australian Privacy Principles will always be upheld if my information is to be shared. I give consent for the doctors and staff of Saratoga Medical to collect and use my information as appropriate to ensure continuity of care. YES ☐ NO ☐

- The Doctors at Saratoga Medical make every effort to provide expert medical care which may include referrals to specialists and/or allied health outside of this practice. I undertake to be responsible for my attendance at the consultations. If I am unable to attend, I will notify the practice. I AGREE/I DISAGREE

- I agree to attend appointments that have been made (with the Doctors/Nurses) at Saratoga Medical and acknowledge that there may be a fee charged if I repeatedly fail to attend without 2 hours notification.

I have read, understand and agree to all the information on this form.

_____ _____
Name (print) Relationship (self/guardian/parent) ***Please circle***

_____ _____
Signature Date

Are you interested in receiving email newsletters and/or related information from this practice? YES ☐ NO ☐
Follow us on Facebook @saratogamedical or Instagram @saratogamedicalcentre

Due to the Privacy Act we need to know if at any time someone else may be collecting personal information for yourself i.e.:

picking up prescriptions or referrals. Please list the name of any person & sign your authority to collect on your behalf and

note that an appropriate form of identification (ID) will need to be produced by this person upon collection.

I _____ authorise _____
(Your name) (Person collecting information)

to collect personal information on my behalf.

This will remain valid until such time I notify the practice otherwise in writing.

Your signature: Date:

_____ _____