New Patient Registration

Ontario Family Practice

Patient Information

Title: _____ **Surname:** _____ **First Name:** _____

***If patient is a child*: Name of Parent / Guardian:** _____

DOB: _____/_____/_____ **Birth Sex:** Male / Female **Gender Identity:** _____

Preferred Pronouns: She/Her/Hers He/Him/His They/Them/Theirs

Aboriginal & Torres Strait Islander: Yes / No **Torres Strait Islander** Yes / No **Aboriginal** Yes / No

Country of Origin: _____ **Occupation:** _____

Address: _____ **Suburb:** _____ **Postcode:** _____

Postal (if different): _____

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

Consent to SMS reminders: Yes / No **Email address:** _____

Next of Kin Contact Details:

Name: _____

Tel: _____

Relationship: _____

Medicare No: _____

Do any of these cards apply? (Please circle)

Card No: _____

Emergency Contact Details:

Name: _____

Tel: _____

Relationship: _____

Exp Date: _____/_____ **Ref No:** _____

Vet Affairs / Pension / Healthcare

Exp Date: _____/_____/_____

Private Health Insurance: YES / NO If yes Fund: _____ Member No: _____

Consult Fees

Payment is required in full at time of consultation. Patients are liable for all Workover and TAC claims. Accounts referred to a debt collection or solicitor will incur a debt collection fee.
By signing this form you understand all procedures of the practice and agree to pay all accounts within the practice's specified time period.

Recall / Reminders

OFP patients are placed on a Recall / Reminder Systems for all Health Checks and Assessments and Care Plans. If you do not wish to participate please advise us.

Declaration

I agree that all information I have provided is true and correct to the best of my knowledge.

Signed: _____ Date: _____/_____/_____

Staff Initials_____ / Reg Dr ☐ / Medicare Chk ☐ / Consent signed ☐ / Records transfer given ☐

Health Information Collection and Use Consent Form

As a patient of our medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat, and be proactive in your health care needs. We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use, and disclosure of your health information. We require your consent to collect personal information about you and to use the information you provide in the following ways: (Please read this consent form carefully and sign where indicated below)

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, for medical tests, and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums, etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Information that does not identify you is used and you may "opt out" of any involvement.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For reminder texts or letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above, but it may influence our ability to manage your health care to provide the best outcome to you.

- ✓ I have read the information above and understand the reasons why my information must be collected.
- ✓ I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.
- ✓ I am aware of my rights to access information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.
- ✓ 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 the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.

OR

☐ I am unsure and would like to discuss this further with someone from the medical practice before I sign.

Patient's Name: _____

Signature: _____

If patient is under 16, signed by parent or guardian