CANTERBURY CLINIC

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Registration form for New Patient (Please complete and hand over to our reception)

Title: _____ Surname: _____

First Name: _____ Middle Name: _____

Preferred Name: _____ Date of Birth: ____/____/____

Gender: Male ☐ Female ☐ X ☐ Ethnicity: _____

Aboriginal: Yes ☐ No ☐ Torres Islander: Yes ☐ No ☐

Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: _____ Mobile: _____

E-mail: _____

Medicare Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Reference Number: _____ (This is the number left of your name) Expiry Date: ____/____/____

Veteran Affairs Number (DVA): _____ Color: _____ Expiry Date: ____/____/____

Other Cards Type: (Please Tick)

Pension Card ☐ Health Care card ☐ Senior Commonwealth Card ☐

Card Number: _____ Expiry Date: ____/____/____

Emergency Contact Person:

Title: _____ First Name: _____ Surname: _____

Relationship to you: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: _____ Mobile: _____

PTO

Next Of Kin:

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

Relationship to you: _____

Address: _____

Suburb: _____ **State:** _____ **Postcode:** _____

Home Phone: _____ **Mobile:** _____

PRIVACY STATEMENT AND FINANCIAL CONSENT

Canterbury Clinic respects your rights to privacy and considers all information for the purposes of the privacy act 2010. Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and ensure this information is only accessible by authorized staff members. I consent to the disclosure of my personal health information by doctors practicing at Canterbury Clinic to provide health care services to you in the most appropriate and efficient way. Where possible we collect information directly from you and where that is most reasonably practical we may collect your personal information from other sources such as health insurers, government agencies, hospitals, doctor and medical specialist. Canterbury Clinic follows a process for collecting and transferring personal information and clinical records, please ask your Medical Practitioner or the Practice Manager for details and transferring records and if a fee applies with the process. I consent to de-identified data (including, without limitation, photographs of my skin and any skin cancers) being used for medical training and medical research by Canterbury Clinic and such data being provided to third parties for these same purposes.

FINANCIAL CONSENT: I agree that the above is a true and accurate record. I understand that Canterbury Clinic requires payment on the day of treatment. Any expenses or costs incurred by Canterbury Clinic in recovering outstanding money including debt collection fees will be paid by the parties above. I also further acknowledgement that failure to attend an appointment without notice may result in a fee charge for the cancelled appointment.

REMINDER SYSTEM

Our Medical Clinic provides our patients with preventative care and early reminders. For example; Immunizations, Annual Health Checks, Pap Smears, Annual Skin Checks, etc.

Do you wish to have the relevant health reminders sent to you? Yes/No

If we need to contact you what is your preferred method of contact? (Please circle)

Home Phone **Mobile** **Mail** **SMS**

Signature: _____

Print Full Name: _____

Date: ___/___/_____