Bluff Road
Medical Centre
Family Health

326--328 Bluff Road Sandringham 3191
T: (03) 95986244 F: (03) 95210154
www.bluffroadmedical.com.au

**NEW PATIENT REGISTRATION**
*Welcome to Bluff Road Medical Centre.*
*Please complete and **GIVE TO RECEPTION**.*

## Section A: Personal Contact Details (*Name as it appears on your Medicare Card*)

**Title**: ☐ Mr ☐ Ms ☐ Mrs ☐ Dr ☐ Prof **Country of Birth:** _____

**Family / Last Name:**_____ **eHealth Record**: Y / N

**Given name**: _____ **Preferred Name:**_____

**Date of Birth:** Day _____ Month _____ Year _____ **Age:** _____ **Gender:** ☐ Male ☐ Female

**Marital status:** _____ **Occupation:**_____

**Interpreter (*Language if required*):** _____ **How did you find out about us**_____

**Home address:** _____ __ **Postcode:**_____

**Postal address:**_____**Postcode:**_____

**Home phone no.:**_____ **Mobile no.:**_____

**Work phone no:.** _____ **Email:**_____

**Practice Status:** *Visitor / Plan to be Regular patient.* **Do you consent to SMS / Email Communication?** Y / N

**Cultural Heritage:** Australian / English / Chinese / Indian / Aboriginal /Torres Strait Islander /Other:_____

**Any Allergies and or Allergic Reactions to Medication ?** Yes/No_____

## Section B: Government Identifiers

**Medicare Card no.:** ☐☐☐☐ ☐☐☐☐☐ ☐ **Patient no. on card:** ☐ **Expiry date:** _____/_____

**Centrelink HCC / Pension Number.:** _____**Expiry date:** _____/_____

**DVA Number** _____ **Expiry date:** _____/_____

## Section C: Emergency Contact / Account Payer

**First Name:** _____**Last Name:**_____

**Relationship to Patient:**_____**Gender:** ☐ Male ☐ Female

**Home phone no.:**_____ **Mobile no.:**_____

***Account Payer:*** **Self / Other Name:**_____**Medicare card no.:**_____

**Address:**_____**DOB:** _____

**Home phone no.:**_____

## Section D: Important Information / Privacy Policy

**Transfer of Health Information:** If you have consulted with another GP at another practice, the Health Information held by that GP may assist us with your future healthcare needs. If you wish to have a copy/summary of your health records transferred to this clinic, please ask reception for information on how this can take place.

**Reminders & Recalls:** Our medical clinic automatically provides our patients with preventive care and early detection reminders and recalls via mail and some other messages by email. If you do ***NOT*** wish to receive such reminders, please advise our reception staff.

**Privacy Policy:** We are committed to maintaining the confidentiality of your personal information in keeping with the Privacy Act, 2001. It is clinic policy to maintain the security of personal health information at all times and to ensure that this information is only available to authorised practitioners. Information may be disclosed to other organisations where required by law or if necessary contact details may be disclosed for debt recovery purposes. Our privacy policy is available on our website. Infection control and instrumental sterilisation processes are adhered to at this clinic.

**Payment details:** **PLEASE NOTE WE ARE *NOT* A BULK BILLING CLINIC and OUT OF POCKET FEES APPLY.**

- Payment in full is requested at the time of consultation. Cash, EFTPOS, Visa, MasterCard all accepted.
- **A $13.00 accounting fee will be charged if your account is not paid in full on the day of the consultation.**
- The patient will accept full Liability for all Workcover and TAC claims.
- Accounts referred to a debt collection Agency or solicitor will incur a debt collection fee.
- By signing this form, you accept the terms and conditions above ( to be signed by the person liable for the accounts)

**Signed:** _____ **Date: Day** _____**Month** _____**Year** _____