



NEW PATIENT REGISTRATION

Please complete and **GIVE TO RECEPTION**
 Or email to practice@bluffroadmedical.com.au

326--328 Bluff Road Sandringham 3191
 T: (03) 95986244 F: (03) 95210514
www.bluffroadmedical.com.au

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

Title: Mr Ms Other _____ Country of Birth: _____
 Family / Last Name: _____ Occupation: _____
 Given / First Name: _____ Preferred Name: _____
 Date of Birth: Day _____ Month _____ Year _____ Age: _____ Gender: Male Female Other
 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.: _____

Please advise reception if aged under 18 years.

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
Reminders & Recalls: Our medical clinic automatically provides our patients with preventive care and early detection reminders and recalls via SMS, email or by mail. 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. Your personal health information may be disclosed to our affiliated medical clinics (to enable us to treat you at those locations), 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 and MasterCard are all accepted.
- **An 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 _____