# GOLDFIELDS UROLOGY PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Surname: _____ Mr/Mrs/Ms/Miss/Dr/Prof/Other _____

Given names: _____

Preferred name if different from above: _____

Residential Address: _____

_____ Postcode: _____

Postal Address *(if different from above)*: _____

_____ Postcode: _____

Date of Birth (DD/MM/YYYY): _____/_____/_____ Sex: ☐Female ☐Male

Phone: (Home) _____ (Work) _____

(Mobile) _____ (E-mail) _____

Do you consent to receive email and SMS communications from this practice?

☐Yes ☐No

## MEDICARE & INSURANCE

Medicare No: _____ Ref: _____ Expiry: _____
*If applicable:*
Hospital Insurance Fund: _____

Hospital Insurance No:: _____

Health Care Card No: _____ Expiry: _____

Pension No: _____ Expiry: _____

Veteran Affairs No: _____ Gold / White Card *(please circle)*

Workers Compensation/TAC Claim No: _____

Date of Accident/Injury: _____

Employee/Insurance Name & Address:

_____

_____

_____

Referring Doctor: _____

Your usual General Practitioner's Name & Clinic (& address if known):

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_____

_____

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Indigenous Status: *(Please tick appropriate box)*

☐ Aboriginal origin ☐ TSI origin ☐ Neither

Country of Birth: _____

Interpreter Required: ☐Yes ☐No If yes, language: _____

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Primary Contact Name: _____ Relationship: _____

Phone (Home): _____ (Work): _____

(Mobile): _____ (E-mail): _____

Secondary Contact: _____Relationship: _____

Phone: (Home): _____ (Work): _____

(Mobile): _____ (E-mail): _____

# PATIENT CONSENT FORM: PRIVACY

We require your consent to collect personal information about you.
***Please read this information carefully, and sign where indicated below.***

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice;
- Billing purposes, including compliance with Medicare and Health Insurance Commission;
- Disclosure to others involved with your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

You have a right to access the information collected on you.

I consent to allow any of my de-identified clinical notes, pathology and clinical photos to be used for teaching purposes; this will also include clinical information for audits or research studies.
I understand that I am not obligated to provide information requested of me, but that my failure to do so might compromise the quality of the health care treatment given to me.
I have read the information above and understand the reasons why my information must be collected.
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 handling of my information by this practice for the purposes set out above, subject to any limitation on access or disclosure of which I notify this practice.
I am also aware that this practice has a privacy policy on handling patient information.

Signed: _____ Date: _____

I do not consent to the above:

Signed: _____ Date: _____

Reason: _____