Sunnybank Plaza Family Clinic
ABN 40 886 273 925

NEW PATIENT REGISTRATION FORM

Welcome To Sunnybank Plaza Family Clinic, Registered General Practice

To assist us in ensuring your information is correct, please complete the following details. Once completed, please hand to a receptionist along with your Medicare Card and your Pensioner Card/ Health Care Card if you have been issued with one.

Please make sure the name written is exactly as shown on your Medicare card.

Title	☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Mast. ☐Other _____				
Surname	_____	**Given Name**	_____	**D.O.B.**	/ /
Preferred Name	_____	**Marital Status**	_____	**Birth Country**	_____
Gender	□ Male □ Female □ Others _____			**Occupation**	
Ethnicity/Race	□ Australian, non-indigenous □ Aborigional but not Torres Strait Islander □ Torres Strait Islander but not aboriginal			□ Both Aboriginal and Torres Strait Islander □ Other, please specify _____	
Address			**Suburb**		**Post code**
Home phone	_____		**Mobile**	_____	
Email			**Work phone**		
Medicare Card No.:	_____	**Ref. No.:** ____	**Expiry:** _____ / _____		
Centrelink Card:	□ Healthcare card	□ Pensioner Card			
DVA Card No.:	**Card Number:** _____		**Expiry Date:** ____ / _____ □ Gold □ White □ Orange		
Next of Kin	**Given Name** _____		**Surname** _____		
Address	_____				
Contact no.		**Alt. contact no.**	**Relationship**		
Emergency contact	**Given Name** _____		**Surname** _____		
Contact no.		**Alt. contact no.**	**Relationship**		
Do you drink alcohol?	□ YES □ NO	**How many?**	_____ Per day _____ Per week	□ Socially	
Do you smoke?	□ YES □ NO	**How many?**	_____ Per day	□ Ex Smoker	
Allergies	□ YES □ NO	If yes, specify:	_____		
Current medications	□YES □ NO	If yes, specify:			

PAST MEDICAL HISTORY	**YES**	**No**	**PLEASE SPECIFY CONDITION(S)**
FAMILY MEDICAL HISTORY	**YES**	**NO**	**PLEASE SPECIFY CONDITION(S) AND WHO**

PLEASE TURN OVER THE PAGE →

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OUR PRIVACY AND MEDICAL INFORMATION

Complying with The Privacy Act, your consent is required for information collected. 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 a full medical history so that we may properly access, diagnose, treat and be proactive in your health care needs. This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside this practice and disclosure to other doctors in the practice including locums to assist in your medical care. This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management, in which your consultation may include the presence of a medical student or GP registrar. All information is de-identified. If you wish to opt out of any research undertaken by the clinic – please inform your doctor. We always wish to assure you that your health information is treated with utmost confidentiality. In accordance with medical legislations, doctors and staff in this practice will not discuss test results over the phone and results are only authorized to release by our Doctors.

OUR COMMUNICATION

By signing this form, you acknowledge that appointment reminders, follow-up reminders and report recalls will be communicated via SMS. This is a courtesy service that we offer, it may not be sent on all occasions and you have the responsibility for making, attending, or cancelling appointments for your recall results. You reserve the right to opt out the SMS service at any time, however, you may not be contacted for recalling the results if your phone number provided is not contactable. You are acknowledged that the risk if you request the results to be send by the email you provided.

YOUR RESPONSIBILITIES

Patients are required to return for a consultation to obtain test results, preferably with the doctor who ordered your tests. If any results are abnormal and/or require urgent attention, we will contact you. Please make sure reception has your current phone number and address details when booking or settling your account. It is crucial that you understand that this is your responsibility to ensure you contact and return for your results.

ALLIED HEALTH TEAM CARE ARRANGEMENT

If a patient has a chronic medical condition, they may be eligible for services under a General Practitioner Management Plan (GPMP) or Team Care Arrangement (TCA). The GP Management Plans and Team Care Arrangements provides you with rebates for accessing allied health team services up to 5 times per calendar year. (including chiropractor, dietician, podiatrist, and physiotherapy…etc.) We provide onsite allied health team with no gap fee. However, it is your responsibility to be aware whether you have exceeded the total of 5 allied health services in one calendar year. If your visits of our allied health team are outside of your rebate limits, you are responsible to pay the service as private fee. The private consultation fee is subject to the service you received.

How did you hear about our practice? _____

□ Please tick only if you do not want your health summary shared / upload to MyHealth Record services.
if you do not want to participate, you need to contact My Health Record Help line: 1800 723 471.

- ✓ By signing this form, you are agreed that that any outstanding fees are payable at time of the consultation
- ✓ I am aware and willing to pay the fee involved if my Medicare GPMP/ TCA services exceed the limit of 5 times per calendar year
- ✓ Non-Attendance Policy applies: Non-Attendance without a valid reason or prior notice will incur $40 fee.
- ✓ Investigations/specialists fees: all fees outside our practice is not within our scope, please double check fees prior investigations/ specialist appointments.
- ✓ By completing the field above, I understand and agree to all the conditions for the service provided by Sunnybank Plaza Family Clinic.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** / /

FOR STAFF USE ONLY

PHOTO ID CHECKED □ **SIGHTED BY:** _____ **DATE:** / /