gladstone street MEDICAL CLINIC

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PATIENT REGISTRATION FORM

Title: (Please indicate) Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Mstr ◯ Dr ◯ Other ◯	
Given Name:	Surname:
Address:	Phone Numbers Home: Work: Mobile:
Date of Birth:	Country of Birth:
Medicare Number: *and* Ref Number:	Expiry Date:
Pension/Healthcare card Number: (if applicable)	Expiry Date: *Please present card to reception for verification*
DVA Number: (if applicable) Colour (please circle) Gold White Lilac Orange	Expiry Date:
Email Address:	
Next of Kin & In Case of Emergency Contact: Name: Relationship:	Address: Phone Number:
Adding Other Family Members? **Under 18 years of age only.** Please attach additional forms if needed	
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Do you identify as Aboriginal &/or Torres Strait Islander? (circle one) YES NO Do not wish to say	

I acknowledge that Gladstone Street Medical Clinic (GSMC) is a private billing clinic and fees apply for all consultations. Payment is expected at conclusion of an appointment or a handling fee applies. For full details see the Practice Information Sheet or ask at reception.

I give my consent to the release of information regarding my treatment (and any family members listed on this form) to other specialist practitioners and/or other GSMC practitioners as necessary. GSMC acknowledges and respects the privacy of individuals. The personal information collected is necessary for us to provide you with the best possible service. By completing this form, GSMC accepts that you, your parents/guardians (if person is under 18 years of age) have consented for this information to be collected. The intended recipients of this information are GSMC and its authorized staff. You have the right to access and alter personal information collected in accordance with the Commonwealth Privacy Act (Amended 2001) and GSMC Privacy Policy.

We will use the information you provide for appointment confirmation, sending reminders, recalls, results and health promotion via SMS, emails, telephone or mail.
I want to receive SMS or other electronic communication (please indicate your choice) ◯ Yes ◯ No

Please read this document carefully before signing. Your signature will be taken as your agreement to the above.

Name: _____ Signature:_____ Date __ /__ /____