THE ABERDEEN MEDICAL CENTRE

Patient Registration Form

We are commited to providing our patients with the best health care.
To do this it is essential that your details are kept up to date and accurate.

Please Complete The Following

Title

Surname: ____________________

First Name: ____________________

Preferred Name ____________________

Date Of Birth: ____________________

Street Address: ____________________

Suburb & Postcode: ____________________

Telephone: Home: ____________________

Mobile: ____________________

Work: ____________________

Email Address: ____________________

Next Of Kin:

Full Name: ____________________

Telephone No: ____________________

Relationship to you: ____________________

Emergency Contact:

Full Name: ____________________

Telephone No: ____________________

Relationship to you: ____________________

What is your nationality?

Australian ☐ Other ☐ Please State: ____________________

Please Turn Over

Do you identify as Aboriginal or torres strait islander

No ☐ Aboriginal ☐ Torres Strait Islander ☐

Would you like health reminders sent to you?

Yes ☐ No ☐ Method:_______________

Preferred Contact Method:

Mobile ☐ Email ☐ Home Phone ☐ Post ☐

Do you consent for our practice to contact you via SMS for all appointment reminders, non urgent results and recall reminders?

Yes ☐ No ☐

We Require your consent to collect personal information about you and to use the information you provide in the following ways. Eg reminders, recalls, communicating with other gps, specialists, allied health, registers, disease notification as required by law and for use by all GPS in this practice when consulting you.

(A full copy of our privacy policy and the australian privacy principles is available at reception upon request)

At all times, we are required to ensure your details are treated with utmost confidentiality. Your Records are very important and we will take all steps necessary to ensure they remain confidential.

I___________________ give my permission for my personal information to be collected, used, and disclosed as decribed above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and i am free to withdraw, alter or restrict my consent at anytime.

____________________ ________________________

Signature Date

If not patient signing - Your Name ________________________________

Your relationship to patient - ________________________________

Please hand your medicare card and any concession cards along with this form back to reception once complete