**BURLEIGH TOWN MEDICAL CENTRE**

Shop 8, 149 West Burleigh Road

PO Box 3107

Stocklands Burleigh Shopping Centre

BURLEIGH TOWN QLD 4220

PHONE: 07 5593 5561 Email: reception@burleightownmedical.com.au

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| **Patient Registration Form - Please complete all sections**  Title:\_\_\_\_\_\_\_\_\_ Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Known As:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suburb\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medicare No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number in front of name:\_\_\_\_\_\_ Expiry Date:\_\_\_\_\_\_\_\_\_\_\_\_  **Concession Card Details:**  Centrelink Pension Health Care Card  Veterans Affairs  ( White  Gold )  Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_  Our practice uses a reminder service to improve quality of your health care and we send reminders by sms, mail or telephone for appointments and procedures such as immunisations, pap smears and other health reviews.  Do you give permission to be contacted with a reminder Yes:No   **Emergency Contacts - Please could we have 2\_individual people as the point of contact in the event of an emergency**  **Next Of Kin - Person 1**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Emergency Contact - Person 2**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Page 1**  **Please turn over and complete following page** |
| **Page 2**  **Australia is a multicultural society, to tailor the appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds - Do you identify as a person from a culturally and/or linguistic diverse background?**  Yes - Please elaborate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **To assist with health initiatives - Are you Aboriginal or Torres Straight Islander?**  Yes -Aboriginal Yes -Torres Straight Islander Yes -Aboriginal & Torres Straight Islander No  |
| In completing this form I understand that my personal information has been collected and I consent for this information to be shared when relevant and appropriate to my treatment. A full copy of our Privacy Policy and Health Information Collection Policy can be obtained from reception.    Our practice follows guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure as required by federal and state privacy laws.  Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.  **Please can you check that you have completed all sections of this form - Thank You**  **Signature of patient or guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| **PRACTICE FEES**  **Standard Consult** **$ 80.00**  **Long Consult $120.00**  **Health Care Card Holders**  **Standard Consult $ 55.00**  **Long Consult $100.00**  **We Bulk Bill for children UNDER 16 and Pension Concession Card Holders** |