

# NEW PATIENT REGISTRATION FORM



Dynamic Doctors Group is committed to Patient Care driven by Values, Expertise and Experience.

Please complete the following form. **All information will be treated confidentially.**

## Section A: Personal details

Title Dr  Mr  Mrs  Ms  Miss  Gender: Male  Female

If you identify as non-binary, please inform one of Front Desk Team Members, or your doctor, and we will amend your details accordingly.

Surname: \_\_\_\_\_

Given names: \_\_\_\_\_

Known as: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: Married  De facto  Single  Widow  Divorced

Australia is a multi-cultural society. Do you identify as being part of a particular cultural group?

(e.g. Maori, Baha'i, Jehova's Witness etc.) \_\_\_\_\_

Please indicate whether you speak a language other than English? \_\_\_\_\_

Are you of an Aboriginal or Torres Strait Islander origin:

Aboriginal  / Torres Strait Islander  / NA

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred Contact method: Home  Mobile  Email

Consent to SMS Reminder: Yes  No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### Emergency Contact (Person we can contact locally in case of an emergency):

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

### Next of Kin

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Person responsible for account: \_\_\_\_\_ Contact no: \_\_\_\_\_

Dr Keith Williams Provider: 2983805F  
Dr Mirna Williams Provider: 2991703K  
Dr Bryan Rostin Provider: 233746HW

Dr Hendrik van Rooyen Provider: 2751395B  
Dr Vivien Dempsey Provider: 2904495L  
Dr Celeste Trichardt Provider: 4589903F

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## Guardian or Parent (must be completed if patient is under the age of 18):

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Guardian\ Parent DOB: \_\_\_\_\_ Gender: Male  Female

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

How did you hear about us: Website / Internet  Personal Recommendation  Facebook

## Section B: Medicare, Concession and DVA

Medicare Card No: \_\_\_\_\_ Reference No: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_/\_\_\_

Health Care / Pension Card: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_/\_\_\_

DVA: \_\_\_\_\_ Expiry Date: \_\_\_/\_\_\_/\_\_\_ Gold  White

## Section C: Reminders and Results

**Reminders:** This practice takes a preventative approach to your health. You may receive a reminder letter, email or text message, or be reminded at your next consult about follow-up preventive care. You may also receive reminder about your appointments. Please indicate your consent to receiving these reminders in electronic format.

Consent: Yes  No

**Results:** This practice will contact you when required with regards to results. We must obtain your consent for messages, i.e. telephone answering machine, mobile message bank and email or text message regarding matters involving your results.

Consent: Yes  No

## Section D: Privacy Policy

I acknowledge that Dynamic Doctors is a Mixed Billing Practice and I agree to pay all charges associated with services or consumables. I am aware that payment is required in full at the end of each consultation, by way of Cash / EFTPOS / Visa or MasterCard. Any accounts not paid on the day will attract an additional administrative fee. Appointments not attended, without reasonable notification, will attract a non-attendance fee.

Dynamic Doctors Group is an AGPAL accredited general practice and as such continuous care is taken to maintain the privacy and confidentiality of your personal information, as prescribed by the Privacy Act and Privacy Principles. When you register as a patient of our practice, you provide consent for our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare. It is the policy of the Practice to maintain the security of personal health information at all times and to ensure that this information is only available to Health Practitioners consulted within the practice and other Health Professionals involved in the management of the patient. Information may be disclosed to other organisations where required by law or if necessary, contact details may be disclosed for debt recovery purposes.

Patient Signature/Guardian/Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_ DOB: \_\_\_\_\_

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