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 Other

Birth Sex: Male Female Other

Gender Identity: Male Female Non-Binary Other

Pronouns: She/Her/Hers He/ Him / His They/ Them / Theirs

Surname: _____

Given names: _____ _____ _____

Known as: _____ **Date of Birth:** _____

Marital Status: Married De facto Single Widow Divorced

Country of Birth: _____

Please indicate whether you speak a language other than English? _____

Are you of an Aboriginal or Torres Strait Islander origin: Aboriginal / Torres Strait Islander / No

Home Address: _____

Postal Address: _____

Home Phone: _____ **Mobile Number:** _____

Work Phone: _____ **Email Address:** _____

Preferred Contact method: Home Mobile Email **Consent to SMS Reminders:** 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: _____

Allergies: (including medication allergies) **Reaction:** **Nil known allergies:**

_____ _____ ☐

_____ _____

NEW PATIENT REGISTRATION FORM

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 Group is a Private Billing Practice. I will be billed by the Health Practitioner which I choose to consult and I agree to pay all charges associated with services and/or consumables. All administrative services, including financial transactions, will be handled by Dynamic Doctors Group, on behalf of the Health Practitioner. 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. I consent to receiving, where applicable, electronic prescriptions via email to my nominated email account. I will keep Dynamic Doctors Group informed of any changes to my email address.

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 Health Practitioners 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**:_____