ASHBURTON FAMILY PRACTICE
249 High Street, Ashburton VIC 3147 I T: (03) 9885 1200 I F: (03) 9885 0688 I www.ashburtonfamilypractice.com.au

# PATIENT REGISTRATION FORM

**Once completed, please hand or email registration form to reception – reception@ashburtonfp.com.au**

## PATIENT INFORMATION

| | |
|---|---|
| Title: | DOB: |
| Family Name: | |
| Given Name: | |
| Preferred Name: | |
| Birth Sex: | Gender Identity: |
| Pronouns: | |
| Country of Birth: | Ethnicity: |
| Are you of Aboriginal ☐ or Torres Strait Islander ☐ or both ☐ origin? | |
| Address: | Postcode: |
| Home Ph: / Mobile: / Work Ph: | |
| Email: | |
| Medicare Card Number: | |
| Position on Card: | Card Expiry: |
| Pension/HCC No: | Card Expiry: |
| Card Type: ☐ Pension Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card | |
| DVA Card Number: | Card Type: |
| I give permission to be contacted for recalls and reminders via SMS and/or email: ☐ Yes ☐ No | |

## NEXT OF KIN & EMERGENCY CONTACTS

| | |
|---|---|
| Next of Kin Name: | |
| Mobile No: | Relationship to you: |
| Emergency Contact Name: | |
| Mobile No: | Relationship to you: |

## ACKNOWLEDGEMENT / CONSENT

I understand that Ashburton Family Practice complies with the Privacy Act (1988) and as part of their privacy policy, they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above, and consent to Ashburton Family Practice collecting, using, storing, and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Ashburton Family Practice to use and disclose my personal information (except when legal obligations must be met).
I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.

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|---|---|
| Patient / Guardian Signature: | Date: |
| Guardian Name: | |