WYNYARD MEDICAL CENTRE
ABN: 62 948 043 760
138 Goldie Street, Wynyard, TAS, 7325
Phone: (03) 6442 2201 Fax: (03) 6442 4222
Website: www.wynyardmedical.com.au

PATIENT REGISTRATION FORM

Your doctor is committed to providing you with the best care. To do this it is essential that your health record is kept up to date and accurate. Thank you for your cooperation & please return your fully completed form to reception.

PART A:

Title:	☐ Mr	☐ Mrs	☐Ms	☐ Miss	☐ Other
Surname:					
First Name:				Middle Name:	
Preferred Name:				Date of Birth:	/ /
Sex:	☐ Male ☐ Female			Sex at birth: ☐ Male ☐ Female	
Street Address:					
Postal Address: (if different to street address) Otherwise put N/A					
Contact Details	Home Phone: Primary contact number: Y/ N			Mobile: Primary contact number: Y/ N	
Email:					
Occupation					
Medicare Number:			Ref No:	Expiry Date	
Name of Health Fund: (For hospital)				Member Number:	
Country of Birth:					
Are you Aboriginal or Torres Strait Islander?	☐ No	☐ Aboriginal		☐ Torres Strait Islander	
DVA Gold / White:				Expiry Date	
Pension / HCC Number:				Expiry Date	
Next of Kin: **Relationship to Patient**	Name: Relationship: Phone Number:			Can this person be contacted if needed?	
Emergency contact *(if different to Next of Kin)*	Name: Relationship: Phone Number:			Can this person be contacted if needed?	

Medical History:

Any Previous Surgeries? Please list			
Do you have a history of any of the following conditions?	☐ Asthma	☐ Bleeding Disorders	☐ Blood Clots
	☐ Diabetes	☐ Migraines/ Headaches	☐ Heart related issues
	☐ Cancer	☐ Insomnia	☐ Depression/ Anxiety
Are you a smoker?	☐ Yes	If yes how many daily would you have?	
	☐ No		
Do you Drink Alcohol?	☐ Yes	If yes how often would you drink? ☐ Daily ☐ Weekly ☐ Monthly	How Many Drinks would you have in a session?
	☐ No		
Please tick the following for any history of adverse reactions to:	☐ Previous reaction to Anaesthetics	☐ Previous reaction to Sulphur	☐Previous reaction to Aspirin
	☐ Allergens ie: pollen/bee stings	☐ Previous reaction to other medication	☐Previous reaction to adhesive tape etc
	☐ Previous reaction to antiseptic lotions or creams	☐ Previous reaction to local anaesthetic agent	☐Previous Anaphylaxis
Please list any Medications you are currently taking including over the counter medications			
Do you live Alone?	☐Yes ☐No	**If No**: who do you live with? ☐ Spouse ☐ Friend ☐ Relatives ☐Partner	
		If Yes: Do you have regular Visitors? ☐ Daily ☐ Weekly ☐Monthly ☐Never	
Any Hobbies/ Sports or Interests?			

Please complete if signing as a parent/guardian:

Parent/Guardian Name:			
Parent/Guardian DOB:			
Parent/Guardian Medicare Number:		Ref No.	

Do you consent to us communicating with you via SMS on your doctor's behalf? **Y / N**

Do you consent to receive news, information about services, promotions and offers from us (and our third-party partners) and consent to your personal or sensitive information being used for this purpose? You may unsubscribe from these communications at any time **Y / N**

Signature:_____ **Date**_____/_____/_____

Part B: Your privacy and medical records

1. In accordance with section 6(1) of the *Privacy Act 1988* (Cth) (**Privacy Act**), all information collected in this practice is treated as 'sensitive information'. To protect your privacy, WMS TAS PTY LTD ACN 139 624 801 ("**Wynyard Medical Centre**") operates in accordance with the Privacy Act and its Privacy Policy. A copy of our Privacy Policy is available free of charge from reception or on our website at **www.wynyardmedical.com.au**

2. Your doctor uses the information you provide to manage your health care which may include using the information for the following purposes (including instructing Wynyard Medical Centre to use the information for the following purposes on your doctor's behalf):
   a. Collect, record and store your personal and health information that will form part of an individual computerised medical record.
   b. Issue reminders for specific health checks you may require, if any, as part of your consultation with your doctor and/or nurse.
   c. Provide you with health information updates, general medical updates and provide your personal and health information to the relevant state and/or national recall reminder registers.
   d. Use your personal and health information to undertake, however not limited to; administrative tasks involved in the running of Wynyard Medical Centre, and for your doctor, billing tasks which includes compliance with Medicare, Health Insurance Commission and other relevant Government agency requirements.

3. You can assist in maintaining the accuracy of your information by advising your doctor or reception of changes in your contact details.

4. Selected information may be disclosed to various other health care providers involved in supporting your health care management (e.g. pathology and imaging providers, hospitals or other specialists). You hereby acknowledge and consent to the disclosure and/or use of your personal health information by Wynyard Medical Centre, your doctor and persons directly or indirectly involved in your personal health care or medical treatment for that purpose, including:
   a. Sending specimens obtained from you to the necessary pathology provider for analysis. As a result, you understand that you may incur an out-of-pocket expense, by which a separate invoice will be issued by the relevant pathology provider. You understand that you will be liable for all expenses incurred.
   b. Disclosing your personal and health information to the relevant medical and allied health service providers involved in your care.
   c. Disclosing de-identified personal and health information for research and quality assurance purposes undertaken by your doctor to improve the quality of both individual and community health care needs and practice management. Wynyard Medical Centre will inform you when such activities are being conducted and give you the opportunity to 'opt-out' of any involvement at any time.
   d. Using your personal and health information by your doctor and other authorised individuals involved in your medical care and treatment, both directly and indirectly.

5. If you have any questions regarding the management of your personal health information or need to arrange access to your records, please ask reception or your doctor, as appropriate.

6. You are not obliged to provide information requested of you, but that your failure to do so may compromise the quality of care provided to you by your doctor.

7. You understand your right to access both your personal and health information held by Wynyard Medical Centre, except in circumstances where access is legitimately withheld. If your personal and health information is to be used for any other purpose, other than what is set above, your further consent will be obtained.

8. You understand it is your responsibility to inform Wynyard Medical Centre at the earliest of any changes to your personal and health information. If any information held about you is inaccurate, you may request to have this altered accordingly.

Appointments and Fees

9. You understand there may be additional charges incurred beyond the standard consultation fee if any additional tests and/or procedures are required.

10. You understand your doctor requires payment on the day for services they provided. Failure to make payment on the day and before close of business may incur an additional administration fee as set by your doctor for the time and resources taken to recover full payment.

11. You understand a non-attendance fee as set by your doctor may be applicable for any missed appointments.

12. You understand a late cancellation fee as set by your doctor may be applicable for any appointments cancelled with less than 24 (twenty four) hours of notice.

13. If your are experiencing financial hardship, you will notify the Practice Manager in writing prior to my appointment so that an appropriate payment plan can be devised and agreed to between you and your doctor.

14. If you have any questions or concerns about any of the information on this form, you will request to speak to the Practice Manager or notify the Practice Manager in writing.

Please sign this form as confirmation that you have read, understood the appointment and fee information and consent to the use of your personal and health information as stated above.

You hereby acknowledge and consent to the disclosure and/or use of your personal health information by WMS TAS PTY LTD ACN 139 624 801 and persons directly or indirectly involved in your personal health care or medical treatment for the purposes set out above.

If you have any questions regarding the management of your personal health information or need to arrange to access to your records, please ask reception or your doctor, as appropriate.

Patient Name: _____ Date of Birth: _____/_____/_____

Signed:_____ Date: _____/_____/_____

If you do not wish for this to occur, please advise reception of your GP.

Privacy Collection Statement

WMS TAS PTY LTD ACN 139 624 801 collects your personal information for purposes related to (or in the case of sensitive information, directly related to) our functions or activities, including facilitating the delivery of health services to you from your health practitioner, informing you of services which may be relevant to you and to communicate with you on behalf of your health practitioner. We may not be able to facilitate the delivery of health services from your health practitioner to you if you do not provide this information. Your personal information may be disclosed to our related bodies corporate, health practitioner, and third-party services providers. Your personal information is kept private and secure, as required by federal and state privacy laws.

Please refer to our Privacy Policy for full details of how we handle your personal information, including how you may access and seek correction of your personal information, complain about a privacy breach, and how we will deal with that complaint.

Thank you for your cooperation & please return your completed form to reception.