New Patient Forms

Thank you for contacting Marketown Health about registering as a patient with this practice.

Please complete the attached forms to register as a New Patient at Marketown Health, making sure that you comply with the following requirements:

1. all forms must be completed clearly & legibly
2. forms must be signed by hand - DIGITAL signatures are not accepted.
3. attach a scan or photo of your Licence or Photo ID (containing your signature) plus your Medicare Card.

Note that Images embedded in the email are unable to be processed.

Please return you completed forms via email to surgery@marketownhealth.com.au

Your registration will be processed, and you will be notified by email when that has been done.

If you have any questions, please contact the practice on 49295691 for assistance.

Regards

The Team at Marketown Health

Attachments

1. MHFRM.7.031 New Patient Registration Form
2. MHRFM.7.021 Patient Consent to collect information

DOC NO. MHFRM.7.031	New Patient Registration	MARKETOWN HEALTH

Please complete this form and return it to the receptionist. This form has 2 pages – see over.

Please ✓ tick the box to indicate your preference.	
Title	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Other
Patient Family Name:	
Patient Given Name:	
Patient Middle Name:	
Date of Birth (dd/mm/yyyy):	
Sex:	☐ Male ☐ Female ☐ Other
I identify my cultural background as: **Optional to answer**	☐ Torres Strait Islander ☐ Aboriginal ☐ Aboriginal and Torres Strait Islander ☐ Other (specify)
Address: **If your postal address is different to your home address, please provide both.**	
Telephone Numbers: I consent to Marketown Health contacting me by phone or SMS	Home Phone: Mobile: ☐ Yes ☐ No
Email address:	
I am willing to receive information from Marketown Health by email.	☐ Yes ☐ No Please note Marketown Health will not discuss personal health information by email

Emergency Contact Person		
In the event Marketown Health needs to contact me, and cannot reach me, I consent to Marketown Health contacting the person named below.		
Emergency Contact:	Name:	
	Relationship:	
	Home Telephone:	Mobile Number:
Financial Details and Entitlements		
If you hold any of the following cards, please complete the details and present the card at reception upon completion of this form.		
Medicare Card	Card No: Ref ID: Expiry:	
Pensioner Health Care Card	Card No: Expiry:	
Seniors Card	Card No: Expiry:	
DVA Card – Gold	Card No: Expiry:	
DVA Card – White	Card No: Expiry:	
Workers Compensation Claim.	Insurance Company: Claim Reference:	
Private Health Insurance	Insurance Company: Member No:	
Consent to contact:	If I do not answer the phone when Marketown Health calls I consent to Marketown Health leaving a message on an answer machine, voice mail or with the person who answers the phone. ☐ Yes ☐ No	
Patient Signature: Electronic signatures are note accepted and will not be processed.		**Date:**

DOC NO. MHFRM.7.021	Patient Consent for collection of personal Information	MARKETOWN HEALTH

Please complete this form and return it to the receptionist.

This medical practice collects personal information from you for the primary purpose of providing health care. Marketown Health complies with the *Privacy Act 1988* (Cth) and the *Health Records and Information Privacy Act 2002* (NSW).

We also use the information for:

- administration of the practice;
- billing, including compliance with Medicare and Health Insurance Commission requirements;
- disclosure to other health professionals involved in your treatment;
- disclosure for research to help improve community health care;
- disclosure for quality assurance review.

Please advise reception if you do not want your records accessed for any purpose other than for consultation with your treating doctor.

Patient Acknowledgement

I acknowledge the purposes for which my personal information is collected. I understand that I am not obliged to provide the information requested from me, but that a failure to do so may compromise the quality of health care that can be provided to me.

I understand Marketown Health has a privacy policy which contains information about accessing and seeking correction of personal information.

I understand that I have a right to access the information collected about me, except in circumstances where it may lawfully be withheld from me. I understand that I will be provided with an explanation if I am refused access to the information collected about me.

I understand that if I choose to access my Patient Heath Information, Marketown Health is entitled to charge a fee to cover administrative costs and consultation with the doctor and this fee is not covered by a Medicare rebate.

I understand that if my personal information is to be used for any other purpose, my further consent will be requested and I may refuse consent.

I consent to the collection and storage of my personal information for the purposes set out above.

Patient Name:	
Patients Signature:	
Date:	