**PATIENT REGISTRATION FORM** – Hello Health Family Practice

**PRIVATE AND CONFIDENTIAL** **- the following form is for the patient requesting an appointment for a Pfizer vaccine**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** | **First Name** | | **Surname** | | **DOB** |
| **Gender** | Male | Female | Intersex | Other | Transgender |

|  |  |  |  |
| --- | --- | --- | --- |
| **Address:** | | | **Postcode:** |
| **Home Phone Number:** | **Mobile Number:** | **Work Phone Number:** | |

**MEDICARE CARD NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref No: \_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Are you:** Aboriginal / Torres Strait Islander / Both? |
| **Occupation:** |
| **Next of Kin (name and phone):** |
| **Do you have any known allergies?:** |
| **Have you received a COVID-19 vaccine before and is so when and which vaccine? :** |

Please provide a photo of you drivers licence or other photo ID as proof of address

\*Please note: The information we are requesting will help us to provide you with the best quality care. Our practice is accredited and follows the guidelines of the Royal Australian College of General Practitioners Handbook for the management of health information in private medical practices. This means your personal health information is kept private and secure, as required by federal and state laws. If you have any concerns, please leave blank and discuss with your GP. This form complies with the Royal Australian College of General Practitioners Standards for general practice.

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Australian Privacy Principles – **Patient Consent Form**

Welcome to Hello Health Family Practice. Please read this consent form carefully before signing.

Hello Health Family Practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and advise you on all your health care needs.

To enable ongoing care, and in keeping with the *Privacy Act 1988* and *Australian Privacy Principles*, we wish to provide you with information on how your personal information may be used or disclosed, and then record your consent or restrictions to this consent.

Your personal information will only be used to for the following purpose for which is was collected or as otherwise permitted by law, and we respect your right to determine how your information is used to disclosed.

My personal health information will be used for the following;

* Administrative purposes to assist in the running of Hello Health Family Practice, for example Billing purposes, including compliance with Medicare requirements.
* Necessary information we must disclose to others involved in my health care, such as specialist doctors, allied health professionals, Pathology and Imaging doctors for medical tests and in the reports from these, returned to my doctor.
* Follow up recall or reminder notices for treatment and preventative healthcare.
* For legal related disclosure (subpoena of records) as required by a court of law.
* For use when seeking treatment by other doctors in this practice.
* Research and quality assurance activities to improve individual and community healthcare and practice management. This may occur when the Practice incorporates patient health records into **de-identifiable** patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information **cannot** be traced back to the individual.
* Health records may be used for identifiable patient health information. This may occur when the practice participates in research activities on behalf of a university as part of professional development activities to be collected. In this instance this practice would seek consent directly from the patient. Identifiable patient information can possibly be traced back to the individual.
* A third party may be present during your consultation. This may include our practice nurse or a medical student.
* Our practice participates in National, State and Territory recall and reminder systems. For example, Breast Screen NSW, National Bowel Cancer Screening Program, National Cervical Screening Test Register and the Australian Immunisation Register.
* To comply with any legislative or regulatory requirements e.g. notifiable disease to Public Health

**Please complete the form below if you understand and agree to the following statements in relation to our use, collection, privacy and disclosure of your patient information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the information above and understand the reasons why my information must be collected, and the purpose for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.

I give my permission for my personal information to be collected, used and disclosed as described above. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing

**Patient Full Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of other if not patient signing (print please) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your relationship to the patient (e.g. Mother, Father, guardian, translator) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**