PATIENT / FAMILY

REGISTRATION

PFD
PYMBLE FAMILY DOCTORS
DEDICATED TO YOUR HEALTH AND WELL BEING

Parent Details: Mr☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other _____

First Name _____ Middle Name _____

Last Name _____ Male ☐ Female ☐

Home Address _____

_____ State _____ Postcode_____

Postal Address (If different) _____

_____ State _____ Postcode_____

Date of Birth ___/___/_____ Occupation _____

Telephone Home _____ Work _____ Mobile _____

Email (Please print) _____

If the practice needs to contact you and leave a message may we use your

Home Yes ☐ No ☐ Work Yes ☐ No ☐

Mobile Yes ☐ No ☐ Email Yes ☐ No ☐ Mail Yes ☐ No ☐

Medicare No. | | | | | | | | | | | | Ref No. | | Valid To | / |

Department of Veterans Affairs File No. _____ Gold ☐ White ☐

Are you entitled to any concessions?

Health Care Card ☐ Pension ☐ Entitlement No. _____Valid to _____

Commonwealth Seniors Health Card ☐

Do you identify yourself as:

Aboriginal ☐ Torres Straight Islander ☐ Other Indigenous ☐ _____

Next Of Kin/Emergency Contact

Relationship to patient _____

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: _____

First Name _____ Last Name _____

Address (if different) _____

_____ Contact Number:_____

Child 1: Name:_____Surname:_____DOB:_____M/C REF:__
Child 2: Name:_____Surname:_____DOB:_____M/C REF:__
Child 3: Name:_____Surname:_____DOB:_____M/C REF:__
Child 4: Name:_____Surname:_____DOB:_____M/C REF:__
Child 5: Name:_____Surname:_____DOB:_____M/C REF:__

P.T.O

PATIENT

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In line with the provisions of the Commonwealth Privacy Act (1988) and the National Privacy Principles, you are asked to give your consent to Pymble Family Doctors for the collection and storage of your personal and health information. The information you provide will form part of your medical record and be stored in our computer system.

It is necessary for us to collect personal information from our patients (and sometimes others associated with their health care) in order look after their health needs and for associated administrative purposes.

No access to your health or other personal information, in any form, will be provided to any unauthorized person or to any person or organization outside of this practice without your express, written permission.

I consent to Pymble Family Doctors recording and storing the information I have provided on this form. I understand that this information will form part of a computerised medical record.	Yes ☐	No ☐
I consent to Pymble Family Doctors using the information I have provided to issue letters to me reminding me when my routine health checks are due. I understand that my doctor will discuss the health checks I need, if any, as part of our consultation.	Yes ☐	No ☐
In the event that I need to be referred for further tests and/or investigations or to a specialist, I give my consent to my doctor disclosing essential personal and health information for that purpose.	Yes ☐	No ☐
I understand that all fees are payable at the time of consultation and that there may be additional charges incurred beyond the consultation fee if any treatment or procedure is required (eg a biopsy).	Yes ☐	No ☐
I understand that any specimen obtained will be sent to a pathology provider for examination and they may send me a separate invoice.	Yes ☐	No ☐

Please ask our reception staff if you have any questions or concerns about any information contained on this form.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____