NEW PATIENT ADULT REGISTRATION FORM

PFD
PYMBLE FAMILY DOCTORS
DEDICATED TO YOUR HEALTH AND WELL BEING

Title (please circle) Mr Miss Ms Mrs Dr Other:
Family name:
Given name:
Middle name
Preferred name:
Date of Birth: / /
Ethnicity:
Address:
City/Suburb: Postcode
Postal Address:
City/Suburb: Postcode

Home phone: Work phone:
Mobile phone:
E-mail:
Medicare No.: *IRN: Expiry:
** IRN is the number on the left side of the name*
Pension/HCC No.: Expiry:
Card Type: (please tick)
☐ Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card
DVA No.: Expiry:
Card Type: (please tick) ☐ Gold ☐ White ☐ Orange
Occupation:
Next of kin & emergency contact (name)
(number) Relationship:

Do you identify yourself as?
Aboriginal ☐ Torres Strait Islander ☐ Other Indigenous ☐ _____

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 unauthorised person or to any person or organization outside of this practice without your express, written permission.

	Yes	No
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.	☐	☐
I consent to Pymble Family Doctors uploading a shared health summary to Myhealth Record?	☐	☐
I consent to Pymble Family Doctors issuing letters/SMS 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.	☐	☐
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.	☐	☐
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 (e.g. a biopsy).	☐	☐
I understand that any specimen obtained will be sent to a pathology provider for examination and they may send me a separate invoice.	☐	☐

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

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____