Meadowbrook
Medical Centre

Patient Registration Form

Please note: UQ Health Care's company policy is that on your initial visit, or at any time at the GPs discretion, the GP will not be able to write a prescription for any medication that the GP deems to be "Drugs of Dependence".

Title	☐ Dr ☐ Prof ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Other: ____________	
Surname		**Date of birth:** _____ / _____ / _______
First name/s		**Known as:**
Birth sex	☐ Female ☐ Male ☐ Intersex	**Gender identify:** ☐ Man ☐ Non-binary ☐ Woman ☐ Other: ________________________________
Ethnicity		**Country of birth:**
Street address		
Suburb		**Postcode:**
Postal address ☐ Same as above		
Home phone		**Work phone:**
Mobile phone		**Email:**
Preferred contact	☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email ☐ SMS	
Occupation		
Medicare card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	No. next to name **Ref No.** ___ **Expiry date:** ____ / ____
Pensioner card	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry date:** ____ / ____ / ______
DVA card ☐ Gold ☐ White	___ ___ ___ ___ ___ ___ ___ ___ ___ ___	**Expiry date:** ____ / ____ / ______
Private Health Fund	**Fund name:** ________________________ __ __ __ __ __ __ __ __ __ __ __	**Expiry date** *(if known)*: ____ / ____ / ______
OSHC/WorldCare Educover	☐ OSHC Worldcare ☐ Worldcare Educover ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___	☐ Single ☐ Family **Expiry date:** ____ / ____ / ______
Parent's details (Only if the patient is under 16yrs)	Name: ______________________________________ Address: ____________________________________ Date of birth: ____ / ____ / _______ Medicare card no.: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No. ___ Expiry date: ____ / ____	
Next of kin	First name: ______________________ Surname: ______________________ Phone: ______________________ Relationship: ______________________	
Emergency contact (Person not in the same household)	First name: ______________________ Surname: ______________________ Phone: ______________________ Relationship: ______________________	

Please now turn the page over

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds - **Do you identify as someone from a culturally and/or linguistic diverse background?**

☐ No

☐ Yes – please explain: ____

What is your preferred language? (if not English): ______________________________________

Knowing your cultural background can help us provide healthcare that meets your individual needs. **Are you of Aboriginal or Torres Strait Islander origin?**

☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Aboriginal and Torres Strait Islander

Privacy of patient information

Our Practice collects personal information and sensitive health information about you and safeguards its confidentiality and privacy in accordance with National Privacy Principles. UQ Health Care's Privacy Policy is available on request, and on display in our waiting room areas.
I acknowledge that my personal information may (where required) be disclosed to other health providers and practitioners so that my health care is not compromised. This information may also be disclosed to other statutory authorities, including insurers and in circumstances where required by law.

Full name: ____

Signature: ______________________________ **Date:** ______ / ______ / ________

Your health data

I give permission to UQ Health Care to store, analyse and publish information collected during my treatment for the purpose of increasing medical and scientific understanding and for educational purposes. I understand that in the event my information is used for the above-mentioned purposes, my identity remains confidential and the information used does not convey my identity under any circumstances.

☐ ***I consent /*** ☐ ***I do not consent*** *(please tick appropriate response) to my health information being used for purposes in the above-mentioned paragraph.*

Full name: ____

Signature: ______________________________ **Date:** ______ / ______ / ________

Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by **post, email, phone** or **SMS** for procedures such as vaccinations, cervical screening, skin checks and other health reviews.

I consent to being contacted with reminders and health promotions to help me maintain my health:

☐ Yes ☐ No

Our practice also sends information to the Australian Childhood Immunisation Register and National Cervical Cancer Screening Register. These registers also send reminders, which can be helpful if you move.

Signature of patient or guardian: ______________________ **Date:** ______ / ______ / ________