saratoga medical

**NEW PATIENT REGISTRATION**

Title:_____ Surname:_____ First Names: _____
Preferred name: _____ Date of Birth: _____ Sex: _____ **Ethnicity:** _____

**Aboriginal: Y N or TSI: Y N**

Address: _____
Postal Address: _____
Telephone: h: _____ wk: _____ mob: _____ **Consent to SMS: Y N**
Email: _____

**Medicare #** _____ Ref #: _____ Exp. Date: _____
Pension # _____ Exp.Date: _____ HCC # _____ Exp.Date:_____
Veteran Affairs Card# _____ Type of Card: _____ Exp. Date: _____
Private Health Insurance # _____ Ref # _____ Exp. Date: _____

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Head of family (for children only): _____
Next of kin: _____ Relationship: _____ Phone: _____
Emergency Contact #: _____ Relationship: _____ Phone: _____

Name/Address/Phone no. of Previous GP: _____

**List any Allergies:** _____
Please list all current medications (including over the counter, herbal or other preparations, as well as prescribed).
_____
_____
Past Operations or significant illness (if any):_____
_____

**Smoking Status: Please circle one:** Smoker / Ex Smoker / Non Smoker

Family History of illness (eg. heart; BP; diabetes; stroke; arthritis; asthma; depression; other)
Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Last Tetanus injection: _____
Immunisation history (for children): _____

In the interest of your health and wellbeing the Practice has a reminder system for some routine health checks.
Please tick as to whether or not you want to be included: YES ☐ NO ☐

Are you interested in receiving email newsletters and/or related information from this practice? YES ☐ NO ☐

We are interested to know how you heard about this surgery.
Referral from another patient ☐ Referral from other doctor ☐ other _____

PHOTO ID PROVIDED & SCANNED YES ☐ NO ☐

**PTO**

**1/10 Village Road, Saratoga NSW 2251 P: 4363 1066 F: 4363 1077**

**Consent**

Please read the information on this form carefully. You are under no obligation to provide consent to the use of your personal information. In the event that you do not consent, we will respect your decision.

Please circle your answer and sign below.

- I give consent for the staff and doctors of Saratoga Medical to contact me on:
  Home phone…….. YES/NO
  Mobile phone…… YES/NO
  If necessary leave a message on an answering machine (if I am unavailable)…… YES/NO

- I understand that the doctors and staff may have to provide details of my ongoing care to third parties Such as other healthcare providers (ie specialist, pathology). I understand the Australian Privacy Principles Will be upheld at all times if my information is to be shared. I give consent for the doctors and staff of Saratoga Medical to collect and use my information as appropriate to ensure continuity of care. YES/NO

- The doctors at Saratoga Medical make every effort to provide expert medical care which may include Referrals to specialists and/or allied health outside of this practice. I undertake to be responsible for My attendance at the consultations. If I am unable to attend I will notify the practice. I AGREE/I DISAGREE

- I agree to attend appointments that have been made (with the doctors/nurses) at Saratoga Medical and Acknowledge that there may be a fee charged if I repeatedly fail to attend without 2 hours notification.

I have read, understand and agree to all the information on this form.

_____ _____
Name (print) Relationship (self/guardian/parent)

_____ _____
Signature Date

Due to the Privacy Act we need to know if at any time someone else may be collecting personal information for yourself ie:

picking up prescriptions or referrals. Please list the name of any person & sign your authority to collect on your behalf and

note that an appropriate form of identification (ID) will need to be produced by this person upon collection.

I _____ authorise _____ to collect personal information
(Your name) (Person collecting information)

on my behalf.

This will remain valid until such time I notify the practice otherwise in writing.

Your signature: Date:

_____ _____