HEALTH WATCH CLINICS
NEW PATIENT REGISTRATION FORM

Health Watch Clinics

PATIENT INFORMATION

❑ Ms. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Master ❑ DR.

Last Name: _____ **Given Name:** _____ **Middle Name:** _____

Date of Birth: _____ / _____ / _____ **Age:**_____ **Birth Sex:** _____ **Gender Identity:** _____

Aboriginal or Torres Strait Islander **Ethnicity:** _____ **Country of Birth:**_____
Yes ❑ No ❑

Preferred Language: _____ **Interpreter Yes ❑ No ❑** **Home Phone: ( )** _____

Street Address: _____ **Mobile Phone:** _____

Suburb: _____**State:** _____ **Post Code:**_____ **Email:** _____

Postal Address: _____ **Driver's Licence No:** _____

Suburb: _____**State** _____ **Post Code**_____ **Passport No:**_____

Next of Kin:_____ **Contact Number:** _____ **Relationship:** _____

Emergency Contact: _____ **Contact Number:** _____ **Relationship:** _____

Medicare Number: ___ ___ ___ ___ / ___ ___ ___ ___ ___ / ___ **REF#** _____ **Expiry Date:** _____

Pensioner/Concession Number: _____ **Expiry Date:**_____

Department Vet Affairs: _____ **Expiry Date:** _____

Commonwealth Seniors Health Care Card: _____ **Expiry Date:** _____

Please advise if you would like to partake in our Reminder system **YES / NO**

NB: Complaints should be raised with the Practice Manager, failure to get satisfaction, further information can be obtained from HADSCO .

Details: Email: mail@hadsco.wa.gov.au Post: PO Box B61, Perth WA 6838

Phone: (08) 6551 7600 or 1800 813 583 (free from Landlines)

WRITTEN PATIENT CONSENT

Welcome to Health Watch Clinics. To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent. Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed. The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence). By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons e.g. General Practice Managers.
- To allow medical students and staff to participate in medical training/teaching using only the identified information.
- To inform an employer, potential employer or a statutory body of your medical history, medical, examination and test results where you give authority for this information to be provided.
- For the purposes of research only where the identified information is used.
- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- For legal related disclosure as required by a court of law.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

I, _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health 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. I agree that the information I have provided here will be included in my medical record, and I understand it may be disclosed to other health professionals in the interest of my ongoing health improvements

Signature: _____ **Date:** _____