Stratford Medical Centre

NEW PATIENT REGISTRATION FORM

Please tick □ Mr □ Master □ Miss □ Mrs □ Ms □ Dr	**Surname**			
Given Names				
Date of Birth				
Street Address				
Suburb			**Post Code**	
Postal Address				
Suburb			**Post Code**	
Home Phone			**Work Phone**	
Mobile Phone				
Email Address Please ensure correct spelling & write clearly				
Occupation				
Medicare Number		**IRN**	**Expiry Date**	
DVA Gold / White			**Expiry Date**	
Pension Card or Health Care Card			**Expiry Date**	
Nationality				
Do you identify as	□ Aboriginal □ Torres Strait Islander □ Both Aboriginal and Torres Strait Islander			
Next of Kin	**Name**		**Relationship**	
	Phone number			
Emergency Contact	**Name**		**Relationship**	
	Phone number			

Please turn over page for Privacy, Consent & Signature

Stratford Medical Centre

Privacy

Your medical record is a confidential document. It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff.
Please refer to our Privacy Policy located at Reception or via our website.

Do you consent to the Doctors at Stratford Medical Centre uploading and accessing your My Health Record?

☐ Yes ☐ No

Do you wish to receive SMS notifications from Stratford Medical Centre?

Appointment reminders ☐ Yes ☐ No

Clinical Reminders ☐ Yes ☐ No

Clinical Communications (Results & Clinical Messages) ☐ Yes ☐ No

Health Awareness (Leaflets & Database) ☐ Yes ☐ No

Do you consent to the Staff at Stratford Medical Centre sending Emails to you which may contain private/clinical information?

☐ **Yes** ☐ **No**

If you request to communicate with us via email, we remind you that this is not encrypted, and we do not send information via this means, without your consent.

Signature: _____ **Date:** _____

Photo ID sited ☐ Staff Signed:_____