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# New Patient Registration Form

| A. Personal | |
|---|---|
| Title | |
| First name | |
| Last Name | |
| Middle name | |
| Date of Birth | |
| Are you Aboriginal or Torres Strait Islander? | Yes No |
| Sex | Male Female Other |
| Address | |
| Phone | Mobile Home/Other |
| Email | |
| How did you hear about us? | Website Word of mouth GP Other: |
| **B.Next of Kin** | |
| Name | |
| Phone number | |
| **C. Insurance** | |
| a. Medicare | Card number |
| | Reference number |
| | Expiry date |
| b. Private insurance | Provider |
| | Member number |

| c. DVA | Gold/White/ Other: |
|---|---|
| d. Pension/Healthcare card number | |
| | Expiry date |

## E. Consent and privacy

Mindoc requires your consent to collect, use and if necessary disclose your medical information towards the provision of healthcare to you. Please read the following carefully before signing. If you require any clarification, we are happy to assist.

1.I give consent for my personal health information to be used for administrative purposes and the coordination of my care at Mindoc, including disclosure to others involved in my healthcare such as referring doctors , specialists, allied health services and diagnostic service providers within or outside Mindoc.
2.I give consent to be a part of Mindoc's appointment reminders and notifications via SMS and/or email.
3.I consent to Mindoc's use of encrypted electronic communications with other health providers.
4.I give my consent for my personal information to be used for Mindoc's quality improvement activities. Information used for quality improvement activities are de-identified and cannot be traced back to the individual.

I have read and understood the above information, I understand that I am free to withdraw my consent at any time by contacting Mindoc.

| Name | Signature |
|---|---|
| | Date: |