NEW PATIENT REGISTRATION

Welcome to Bayside Family Medical

*Please complete and **GIVE TO RECEPTION.***

1220 Nepean Hwy, Cheltenham, 3192
T:(03) 9583 1630 F: (03) 9585 0560
www.baysidefamilymedical.com.au

Section A: Personal Contact Details (*Name as it appears on your Medicare Card*)

Title: ☐ Mr ☐ Ms **Other** ☐________________ **Country of Birth:** ______________________

Family / Last Name:__________________________________ **Occupation:**____________________

Given / First name: ______________________________ **Preferred Name:**_________________________

Date of Birth: Day ______ Month _____ Year ________ **Age:** ________ **Gender:** ☐ Male ☐ Female ☐ Other

Interpreter (*Language if required*): _________________ **How did you find out about us**___________________

Home address: ____ __ **Postcode:**__________

Postal address:____**Postcode:**__________

Home phone no.:______________________________ **Mobile no.:**___________________________________

Work phone no:. ______________________________ **Email:**______________________________________

Practice Status: *Visitor / Plan to be Regular patient.* **Do you consent to SMS / Email Communication?** Y / N

Cultural Heritage: Australian / English / Chinese / Indian / Aboriginal /Torres Strait Islander /Other:_________

Any Allergies and or Allergic Reactions to Medication ? Yes/No____________________________________

Section B: Government Identifiers

Medicare Card no.: ☐☐☐☐ ☐☐☐☐☐ ☐ **Patient no. on card:** ☐ **Expiry date:** _____/________

Centrelink HCC / Pension Number.: ________________________________**Expiry date:** _________/_________

DVA Number ____ **Expiry date:** ________/__________

Private Health Fund____________________________**Member No:**______________ **Patient no. on card**_____

Section C: Emergency Contact / Account Payer

First Name: ___________________________________**Last Name:**_______________________________

Relationship to Patient:__________________**Gender:** ☐ Male ☐ Female

Home phone no.:_______________________ **Mobile no.:**_________________________

Account Payer: **Self / Other Name:**_________________________**Medicare card no.:**_________________

Address:____________________________________ ___________________________ __**DOB:** _____________

Home phone no.:______________________________

Please advise reception if aged under 18 years.

Section D: Important Information / Privacy Policy

Transfer of Health Information: If you have consulted with another GP at another practice, the Health Information held by that GP may assist us with your future healthcare needs. If you wish to have a copy/summary of your health records transferred to this clinic, please ask reception for information.
Reminders & Recalls: Our medical clinic automatically provides our patients with preventive care and early detection reminders and recalls via SMS, email or by mail. If you do ***NOT*** wish to receive such reminders, please advise our reception staff.

Privacy Policy: We are committed to maintaining the confidentiality of your personal information in keeping with the Privacy Act, 2001. It is clinic policy to maintain the security of personal health information at all times and to ensure that this information is only available to authorised practitioners. Your personal health information may be disclosed to our affiliated medical clinics (to enable us to treat you at those locations), other organisations where required by law or if necessary contact details may be disclosed for debt recovery purposes. Our privacy policy is available on our website. Infection control and instrumental sterilisation processes are adhered to at this clinic.

Payment details: PLEASE NOTE WE ARE *NOT* A BULK BILLING CLINIC and OUT OF POCKET FEES APPLY.

- Payment in full is requested at the time of consultation. Cash, EFTPOS, Visa and MasterCard are all accepted.
- **An accounting fee will be charged if your account is not paid in full on the day of the consultation.**
- The patient will accept full Liability for all Workcover and TAC claims.
- Accounts referred to a debt collection Agency or solicitor will incur a debt collection fee.
- By signing this form, you accept the terms and conditions above (to be signed by the person liable for the accounts)

Signed: ____ **Date: Day** _________**Month** ________**Year** _________