gp on beaufort patient registration form

Please assist us by completing the following, and handing back to reception

Personal Details

Family Name ______________________________ **First Name** ______________________________

Street Address ____

Suburb ____ **Post Code** ________________

DOB ____________________ **Sex M / F** **Ethnic Origin** ______________________________

Home Ph ___________________________ **mobile** ____________________________________

E-mail ____

I give my consent to be contacted by the practice for

- **Results** yes ☐ no ☐
- **Reminder** yes ☐ no ☐
- **Promotions** yes ☐ no ☐

My contact preference is: (h) Phone : email : mobile (please circle)

To assist with health initiatives – are you Aboriginal or Torres Strait Islander origin? Yes ☐ **no** ☐

CARD DETAILS

Medicare Card ___ ________________________ **Ref No.** _____ **Expiry Date** _______________

Health Care Card ___ _________________________________ **Expiry Date** _______________

Pension Card___ ____________________________________**Expiry Date** _______________

DVA Card ______________________________ **gold / white** **Expiry Date** _______________

Seniors Card YES ☐ **NO** ☐

Person Responsible for Account _______________________________________

Drivers Licence to be checked (by staff) ☐ **yes** ☐ **no** ☐ **not provided by patient**

NEXT OF KIN DETAILS

Name ____

Contact phone number in case of emergency (h) ________________ **(m)** ______________________

Relationship ____________________________

PLEASE READ THE PRIVACY POLICY OVERLEAF.
IF YOU AGREE PLEASE SIGN AND DATE THIS DOCUMENT.

I have read the privacy policy of gp on beaufort, and I understand the reasons why my information must be collected.
I understand that I am not obliged to provide this information requested, but my failure to do so might compromise the quality of healthcare and treatment given to me.
I am aware of my rights to access this information, except in some circumstances and I understand that an explanation will be given in these circumstances.

Patient / Parent / Guardian (please circle one)

Signature_________________________________ date ______________________________

AGPAL ACCREDITED GENERAL PRACTICE