Gynaecology and Fertility Victoria

New Patient Registration Form

PATIENT DETAILS

CONTACT INFORMATION

Title	
First Name	Preferred Name
Last Name	
Date of Birth	
Address	
Suburb	Post Code
Phone (Home)	Phone (Work)
Phone (Mobile)	
Email Address	

MEDICAL HISTORY

List any medications including vitamin and mineral supplements
Allergies
List your medical history and any previous illnesses

MEDICARE AND HEALTH INSURANCE

Medicare Number
Medicare Reference Number
Medicare Expiry Date
Healthcare Card Number
Private Health Insurance Insurer
Private Health Insurance Number

Gynaecology and Fertility Victoria

EMERGENCY CONTACT

Emergency Contact
Relationship to You
Emergency Contact Phone (Home)
Emergency Contact Phone (Mobile)

YOUR GENERAL PRACTITIONER

GP Name
GP Address

PARTNER DETAILS (IF APPLICABLE)

CONTACT INFORMATION

Title	
First Name	Preferred Name
Last Name	
Date of Birth	
Address	
Suburb	Post Code
Phone (Home)	Phone (Work)
Phone (Mobile)	
Email Address	

MEDICAL HISTORY

List any medications including vitamin and mineral supplements
Allergies
List your medical history and any previous illnesses

MEDICARE AND HEALTH INSURANCE

Medicare Number
Medicare Reference Number
Medicare Expiry Date
Healthcare Card Number
Private Health Insurance Insurer
Private Health Insurance Number

EMERGENCY CONTACT

Emergency Contact
Relationship to You
Emergency Contact Phone (Home)
Emergency Contact Phone (Mobile)

YOUR GENERAL PRACTITIONER

GP Name
GP Address

CONSENT

In accordance with the Privacy Act (1988), all information collected in this practice is treated as sensitive information. To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your healthcare. You can assist in maintaining the accuracy of your information by advising the practice of changes to your address, phone number etc.

Selected information may be disclosed to various other health services involved in supporting your health care management (eg pathology and radiology).

☐ I consent to the use of my personal health information by Gynaecology and Fertility Victoria and other health providers involved in my medical treatment and health care.

☐ I consent to the disclosure of my personal health information by the abovenamed practice to other health providers directly or indirectly involved in my personal care or medical treatment.

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Signature and Date