Brecken Health
BUILT TO CARE

Patient Registration:
Please complete all sections.

Please circle: Mr Mrs Ms Miss Master **Other:** _____

First Name: _____ **Surname:** _____

Date of Birth: _____ **Birth Sex:** Female / Male / Other / Unknown

Occupation: _____ **Gender Identity:** Female / Male / Non-Binary / Gender Diverse / Transgender

Health Insurance Provider: _____

Health Insurance Number: _____ **Pronouns:** she/her/hers he/him/his they/them/theirs

Address: _____

Suburb: _____ **Postcode:** _____

Home Number: _____ **Work Number:** _____

Mobile: _____

Email Address: _____

Country of Birth: _____ **Ethnicity:** _____

Language spoken (if other than English) _____

Are you of Aboriginal or Torres Strait Islander Origin: Yes / No

Medicare Card Number: _____

Please note: new patients not registered with Medicare are required to supply photo identification on registration

Line Number (next to your name): _____ **Expiry:** _____

Centrelink HCC Number: _____ **Expiry:** _____

Centrelink PENSION Number: _____ **Expiry:** _____

DVA Card Number: _____ **Expiry:** _____

Next of Kin Name: _____

Address: _____

Relationship to You: _____ **Phone Number:** _____

Emergency Contact Name: (tick if same as above ☐) _____

Address: _____

Relationship to You: _____ **Phone Number:** _____

Name of Last Doctor / Surgery: _____

Preferred Contact: Email / SMS / Letter **Do you wish to receive SMS appointment reminders: YES / NO**

Prescriptions: Paper Copy / Email Token / SMS Token

How did you hear about us? Please circle all that apply:

Word of Mouth / Chemist / Corporate Medical / Internet Search / Radio / Signage / Emergency Dept. Television / Newspaper / Referral / Referral from Other Surgery

Have you read and understood the privacy policy and fee structure? YES NO

This is located on the laminated forms attached to the clipboard

Please note we are a private billing practice

I understand the above Medical Practice complies with the Privacy Act (1988) and as part of their Privacy Policy they are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. I understand that I have the right to request access to my information except where access would be denied and that the above Medical Practice makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. I understand that I may withdraw my consent for the above Medical Practice to use and disclose my personal information (except when legal obligations must be met).

My signature below indicates that I have read the above and consent to: (cross out what is not relevant)

- The above Medical Practice collecting, using, storing and disposing of my personal information
- The release of relevant information by the above Medical Practice to other health professionals (e.g. specialist, pathologist)
- Inclusion in a recall register to be advised of follow up visits, medical updates and health information
- Contact by the practice via electronic means (including but not limited to mobile phone, SMS, email and internet)
- The release of relevant personal information to my employer, their authorized representatives and their insurer in the case of a work related consultation or service
- I understand that all accounts must be paid at the time of the consulation

Signature _____ **Date** _____

Please turn over for Medical Questionnaire