GANDANGARA HEALTH SERVICES

64 Macquarie Street, Liverpool, NSW, 2170
PH: 02 9601 0700
FAX: 02 9056 5511

Gandangara Health Services

NEW PATIENT REGISTRATION FORM

Title: **Given Names:** **Last Name:**	
Birth Gender: **Identify As:** **Pronouns: She/Her He/Him They/Them**	**Medicare No:** **Patient No:** **Expiry Date:**
Date of Birth:	
Patient Address:	**Health Care Card No:** **Expiry Date:**
Telephone No: **Mobile Number:** **Email Address:** **Marital Status:** **Occupation:** **Country of Birth:** **Ethnicity:**	**Concession Card No:** **Expiry Date:**
	Veteran Affairs No: **Expiry Date:**
Next of Kin: **Relationship to you:** **Phone No:**	**Are you Aboriginal and/or Torres Strait Islander?** **If Yes, Please Indicate Whether You Are:** **Yes / No**
Emergency Contact: **Relationship to you:** **Phone No:**	**Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander** ☐
Do You Have Any Known Allergies? YES / NO **If Yes, Please Advise:**	

THIS PRACTICE HAS A POLICY OF NOT PRESCRIBING BENZODIAZEPINES OR OPIATES.
PLEASE DO NOT ASK AS REFUSAL OFTEN OFFENDS.

Please Turn Page To Complete Registration Form →

Gandangara Health Services

We require your consent to collect personal information about you.

Please read this information carefully and sign where indicated below.

You acknowledge and agree to the medical practice collecting information from you for the primary purpose of providing health care. We operate recall, reminder and health promotion messaging services (via email, physical mail and text messaging) that utilise the contact information you have provided to us.

During a consultation, your doctor may ask personal details and obtain a full medical history so that he/she may properly assess, diagnose, treat and be proactive in your health care needs.

You acknowledge and agree that your information may be used in the following ways:

- for administrative purposes for running the medical centre (including sending you recalls, reminders and health promotion messages when necessary);
- for billing purposes including compliance with Medicare and Health Insurance Commission requirements;
- disclosure to other doctors in the practice, locums and registrars attached to the practice for the purpose of health care and teaching. You are to advise the medical practice if you do not want your records accessed for these purposes and your chart will be noted accordingly; and
- disclosure for practice accreditation which is used to improve individual and community health care and practice management. You are to advise the medical practice if you do not want your records accessed for these purposes and your chart will be noted accordingly. I have read the information above and understand the reasons why my information must be collected.

I am also aware that this practice has a Privacy Policy on handling patient information in line with the *Health Records and Information Privacy Act 2002* (NSW).

I understand that I am not obligated to provide information requested for me, but failure to do so may compromise the quality of health care and treatment I receive.

I am aware of my right to access information collected about me, except in some circumstances where access might be legally withheld.

I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above subject to any limitations on access or disclosure that I notify the practice of.

Do you consent to receiving SMS (mobile text message) for:

	Yes	**No**
Appointment reminders		
Recall		
Test reminders		
Notification of available health care services		

Signature:…… Date:……..

(Patient or caregiver signature)