Patient Registration Form

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BRIGHTON Spine&Sports CLINIC

Title: _____ Date of Birth: _ _ / _ _ / _ _ _ _ Occupation: _____

First Name: _____Surname: _____

Address: _____ Suburb: _____

State: _ _ _ Post Code: _ _ _ _ Phone: (hm) _____ (mob) _____

Would you like to receive SMS reminders? Yes ◉ No ○ Gender: _____

Email: _____ (for practitioner communication\service info)

Medicare No: _ _ _ _ _ _ _ _ _ _ _ Patient Ref No: ___ Exp: _ _ / _ _ _ _

Next of Kin: _____ Relationship: _____ Telephone: _____

If you would like us to write to your GP or other practitioner and keep them updated as to your progress, please provide name and contact details: _____

_____

Referred by: ☐ Social Media ☐ Signage ☐ Google ☐ Website (specify) _____

☐ Practitioner (Name & Type) _____

☐ Voucher ☐ Family/Friend _____ Other (please specify)_____

Name of Payer if other than yourself: _____

Address: _____

If this appointment is related to a WORKCOVER *or* TAC *claim, please provide details (as appropriate)*

Claim Number: _____ Date of Injury: _ _ / _ _ / _ _ _ _

Insurer's Details (including address): _____

Employer and Address (if applicable): _____

** Accounts must be settled privately at time of consultation if these details cannot be provided.*

Patient personal and medical detail collection is undertaken and data is stored in accordance with the requirements of the *Health Records Act 2001* (Vic) Health Privacy Principles and the Australian Privacy Principles, March 2014. Any queries or complaints can be directed to the practice manager. Your data will never be supplied to any international entity. Signed written consent from the patient is required prior to the release of any personal details or medical information.
Doctors at our clinic use POLAR GP software to help us provide you with the best care. The information is secure, cannot identify patients and is shared with your local Primary Health Network to improve health services in the area. Please let reception staff know if you do not want your information to be included.

A full copy of our privacy policy is available from our website: **http://www.brightonspinal.com.au**

Consent:
I hereby authorise my practitioner(s) to communicate with other health practitioners regarding my condition as necessary. I understand that a fee will be charged if I do not attend or give less than 24 hours notice of cancelling for my appointments._____ _ _ / _ _ / _ _ _ _

(Signature) (Date)

Please list medications:	Please list allergies:

Once completed, please "Save As" the file in the format: SurnameFirstNameDateofBirth (no spaces & numbers only) and e-mail to:
reception@brightonspinal.com.au