441 Bay Street, Brighton 3186
T: 9596 7211 F: 9596 7871
E: reception@brightonspinal.com.au
www.brightonspinal.com.au
ABN 41 821 315 542

BRIGHTON Spine&Sports CLINIC

Patient Registration Form

Surname: ________________________________ First Name: ________________________________

Title: __________ Sex at Birth: ________ Pronouns: _________ Date of Birth: _ _ / _ _ / _ _ _ _

Address: ____ Suburb: __________________________

State: _ _ _ Post Code: _ _ _ _ Phone: (hm) ______________________ (mob) _______________________

Would you like to receive SMS reminders? Yes No

Email (for practitioner communication\service information): ____

Next of Kin: ____________________ Relationship: _______________ Telephone: _____________________

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

Dr Wilk patients ONLY: Private Health Insurer: ___________________ Policy Number: ________________

How did you hear about us?

☐ Social Media ☐ Voucher ☐ Sporting Club ☐ School ☐ Signage ☐ Online

☐ Family/Friend ☐ Practitioner (Name & Type) ________________________________

☐ 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.*

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: ____

____

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. This will include providing education and training in areas of need, identification of service gaps, commissioning and incentivising of new services, and evaluating program outcomes. 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 reception team at any time.

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: