ATTICUS HEALTH
Driven by Soul

General Practice • Allied Health • Aged Care • Corporate Health

Patient Registration Form

Title (please circle) Mr / Mrs / Ms / Miss / Mast Gender (please circle) Male / Female

Surname: _____ First Name: _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Address: _____

_____ Postcode: _____

Postal Address: _____ Postcode: _____

Home Ph: _____ Work Ph: _____ Mob: _____

Email: _____

Medicare No: _____ Ref No: _____ Expiry: ____/_____

If patient is a minor, NOK Medicare No: _____ Ref No: _____ Expiry: ____/ _____

Pension / Health Care Card No: _____ Expiry: ___/___/___

Dept of Veterans Affairs No: _____ Expiry: ___/___/___

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from a culturally and / or linguistic diverse background?

☐ Yes – Please elaborate _____

To assist with health initiatives – are you Aboriginal or Torres Strait Islander?

☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait Islander

☐ No

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Do you consent to receive SMS to confirm appointments? ☐ Yes ☐ No

Would you like to receive our monthly newsletter? ☐ Yes ☐ No

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and cervical screening.

Do you consent to participate? ☐ Yes ☐ No

Next of kin / Emergency contact person: _____

Relationship to you: _____

Address: _____

Home phone No: _____ Mobile: _____

How did you hear about us?

☐ Friend / family ☐ Internet ☐ Walked by ☐ Other _____

Patient Consent Clause

We require your consent to enable us to handle personal information about you. We use a variety of reminder systems to maintain your health where reminders or recalls may be sent by post, email, telephone or SMS. This practice operates in accordance with the Privacy Act. Please read our privacy policy, and sign below. If you have any queries about this, feel free to ask us for further explanation.

I have read the Privacy Policy of Atticus Health and I consent to the disclosure of my personal health information by Atticus Health to other health providers involved in my medical treatment and health care. As part of the preventative health and follow up service offered by Atticus Health, I consent to receive follow up reminders and recalls to be sent to the above address.

Signature: _____ Date: _____