



General Practice | Telehealth | Aged Care | Workplace 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: _____