MQ Health
MACQUARIE UNIVERSITY
HEALTH SCIENCES CENTRE

Patient registration form

Personal details

Title First name Middle name(s)

Surname

Address

Suburb State Postcode

Date of Birth / / Sex: Male Female

Day Time Phone After Hours Phone

Email address

Are you: Macquarie University Staff MUH or MQ Health staff Domestic Student International Student N/A

Country of Birth Cultural Background

Are you: 1. Aboriginal 2. Torres Strait Islander 3. Aboriginal & Torres Strait Islander 4. Neither

Do you require an interpreter or other communication service? Yes No

Emergency Contact Relationship Contact number

Medical correspondence

Are there any other medical practitioners (including your regular GP) you would like to have copied on your correspondence apart from your referring doctor? Please list below

Name Address Phone

Name Address Phone

Medicare/Health Insurance information

Medicare No Ref No (number next to name) Expiry date /

Dept. Veteran Affairs Card No: Gold / White / Other (please specify) Expiry date /

Pension No Expiry date /

Health Care Card No Expiry date /

Private Health Fund Membership No Reference No

Overseas visitors/ students only: OSHC Allianz OSHC NIB OSHC Medibank Private

Insurance policy number – overseas students only Other:

Is this visit related to Workers Compensation or Third Party Injury? Yes No

If yes, please provide your approval letter. If you have not organised pre-approval from your Insurance Company you will be charged the Workers Compensation rate for your visit. You will then need to claim the fee back from your insurance company.

Please turn overleaf ▸

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Privacy consent and information

MQ Health complies with The Privacy Act 1988 – for further information visit http://www.privacy.gov.au

MQ Health requires your consent to collect, use, and disclose, information about you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise you on all your health care needs.

Please read the following carefully before signing. We encourage you to ask questions or seek clarification if needed. By ticking the boxes below and printing your name (as a patient or a guardian of a patient), you acknowledge the following:

- ☐ I give consent for my personal health information to be used for administrative purposes to assist in the running of MQ Health and the coordination of my care, including disclosure to others involved in my healthcare such as referring doctors, treating doctors and/or specialists, allied health services and diagnostic service providers within and outside of MQ Health.
- ☐ I give consent to be part of MQ Health's appointment reminders and notifications.
- ☐ I give consent to be part of recall and reminder systems for national registry purposes (e.g. cervical screening, bowel cancer screening) and for follow up of care provided at my appointment.
- ☐ I give consent for my personal health information to be used in quality improvement activities to improve individual, community health care and practice management. Information used for quality improvement activities is de-identified and cannot be traced back to the individual.
- ☐ I consent to receiving information about research projects being conducted by and through MQ Health and Macquarie University.
- ☐ I have read and understand the above information. I understand I am free to withdraw my consent at any time by contacting the relevant MQ Health clinic.

Signature

Name of Parent/Guardian/Carer (if patient under 18 years of age)

How did you find out about this Clinic? (please tick those most applicable)

- ☐ Family member
- ☐ Friend
- ☐ GP
- ☐ Specialist
- ☐ MQ Health website
- ☐ Internet Search
- ☐ Advertising/Media/Mailbox drop
- ☐ Other (please specify)