**SOUTH WEST ONCOLOGY – Patient Registration**

……………… ……………………………………… ………………………………………… ………………………………………………….

Title Family Name Given Name Preferred Name

……………………………… Male Female Single Married Defacto Separated Divorced Widow

Date of Birth

Home address…………………………………………………………………………………………………………………………………………………………...

…………………………………………………………………………………………………………………………………………………Postcode ………………….

Postal address if different to above ……………………………………………………………………………………………………………………………

………………………………. ……………………………………. ……………………………………………………………………………..

Home Phone Work phone Mobile

Preferred contact method home work mobile Do you consent to be contacted via SMS Yes No

Email address…………………………………………………………………………………………………………………………………………………………….

Medicare card no……………………………………………………………... Ref no. ……………… Expiry date …………………………………

Do you have a Pensioner Concession Card Healthcare Card Veterans Affairs Card

Card Number …………………………………………………………… Exp date ………………… Colour of Vet Affairs Card …………….

Do you have Private health insurance? Yes No

Fund Name ……………………………………………………………………… Membership number ……………………………………….

**Ethnicity: Knowing your cultural background can help us provide health care that meets your individual needs**

Do you identify as Aboriginal or Torres Strait Islander? Yes No

Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander Non Aboriginal/Torres Strait Islander

Other Cultural background details …………………………………………………………………………………………………………………………...

Is English your first language spoken? Yes No If not, language spoken ……………………………………….

Do you require an interpreter? Yes No

Name of GP and Clinic (if not referring dr) …………………………………………………………………………………………………………………

Next of Kin/contact person ……………………………………………………………………………………………………………………………………...

Relationship ……………………………………………………………………. Phone .…………………………………………………………………

**Would you like to be referred to?**

**Prostate Cancer Nurse Yes No Breast Cancer Nurse Yes No**

**Cancer Support Nurse Yes No**

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and keep them updated at all times. We also require a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

* Administrative purposes in running our medical practice
* Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
* Disclosure to others involved in your health care, including nominated next of kin, treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
* Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note your record accordingly.
* Disclosure for research and quality assurance activities to improve individual, community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement.

*I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.*

*I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.*

*I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.*

*I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.*

*I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I will notify your practice.*

Signed………………………………………………………Date…………………………