Registration Form

Gateway Plaza FAMILYMEDICALPRACTICE

Title: Mr. / Mrs. / Ms./ Master / Miss/Other Patients First Name:_____ Surname:_____ Date of Birth:_____/_____/_____ Birth Gender: MALE/FEMALE Current Gender Identity:_____ Pronouns: She/He/They (Please Circle) Address:_____ Suburb:_____P/Code:_____ Preferred Contact No :_____ Email:_____ If Patient is a under 16yrs please provide name of Parent/Guardian:_____	Medicare Number:_____ Reference Number: (Next to your name)_____ Expiry:_____ DVA Number:_____ Expiry:_____ (Please Circle) Pension / Seniors / Health Care Card Number:_____ Expiry:_____

Emergency Contact (please ensure that this contact number is **different** from the number provided above. Children require **2** points of contact)

Name:_____Relationship:_____
Contact Number:_____

1. Are you of Aboriginal **YES/NO** and/or Torres Strait Islander **YES/ NO** origin?
2. Do you wish to identify with another cultural origin? **YES** _____

If you are a new patient:
Are you a visitor? **YES/NO** - Moved to this area? **YES/NO** - Changed from another practice? **YES/NO**
Who is your regular GP or name of surgery? _____

This practice provides our patients with preventative care and early case detection reminders, e.g.: immunizations, blood test, Pap smear and bone density testing. This may require our staff to access your medical files to obtain relevant information. Please advise the Doctor if you do not wish to participate in recall and reminder systems**.** Your information is also transferred to Medicare for billing purposes.
This practice participates in research projects and as such, suitable participants are often selected and sent a letter of invitation. Patients are under no obligation to join.
Sign Acknowledgement_____

Worker's Compensation/TAC: remain subject to the usual terms & conditions for the payment of our accounts. You will be responsible to meet your cost and to claim reimbursement in accordance with your entitlement, unless alternative arrangements have been made and communicated to us by the insurer in respect to the management of your claim.
If the patient is not registered with Medicare then it is the patient's (or payer's) responsibility to pay the account on completion of the appointment.

I agree to the Gateway Plaza Family Medical Practice Terms and Conditions of payment. **YES
I understand the Practice has a non-refundable "Failure to Attend Fee" that I may receive if I fail to attend an appointment. **YES

Signed_____ **Date**_____
We appreciate the time taken to complete this form. **Thank you**