HMP PATIENT REGISTRATION SHEET **FILE NO.**

SURNAME : .... GIVEN NAME :...

DATE OF BIRTH :...................................... OCCUPATION:..

ADDRESS :...POST CODE...........

TELEPHONE (home) .... (work) ....(mob)..

EMAIL............................. NEXT OF KIN: ....

MARITAL STATUS : .... SEX : .... COUNTRY OF BIRTH:..........................

MEDICARE NUMBER :...REF NO: .... EXP DATE.............

CENTRELINK PENSION / HCC NUMBER :..EXP DATE................

DVA CARD NUMBER :..FULL DVA / LIMITED DVA

SNRS CARD NO.: ....

ABORIGINAL : YES / NO TORRES STRAIT ISLANDER : YES / NO

Privacy and personal Information
Hawker Medical Practice uses the information on this form to assist it in managing and planning the patient's medical and health problems . The collection , storage and release of the information provided is protected under the Privacy Act 1988 . Hawker Medical Practice only give this information to someone else where the patients gives permission , or in special circumstances where Commonwealth legislation allows or requires it .

CONSENT for use of information

I , ..., confirm the information I have given is correct . I consent to my nominated treating doctor , doctors and staffs of Hawker Medical Practice , other treating practitioners and allied health providers exchanging all relevant information for the purpose of managing my health and medical problems . I understand this information will be used by doctors and staffs of Hawker Medical practice to fulfil their functions as general practitioners working in an accredited general practice for my health care planning and management of my medical conditions .

I understand that I have the right to request my nominated treating doctor NOT to release certain information , the details of which will be discussed in confidence with my nominated doctor . I have received a copy of the Practice handbook.

Signature :.. Date :...............................