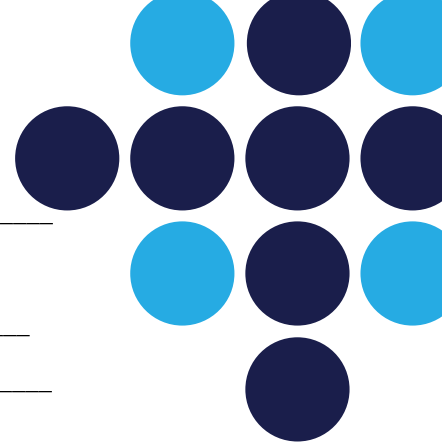


# HEIDELBERG WEST MEDICAL



Title: \_\_\_\_\_

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Ethnicity / Nationality: \_\_\_\_\_

Medicare #: \_\_\_\_\_ IRN: \_\_\_\_\_ Expiry: \_\_\_\_\_

Are you of Aboriginal or Torres strait islander origin? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed  
☐ De-facto

I permit Heidelberg West Medical to contact me via SMS ☐ Yes ☐ No

I permit Heidelberg West Medical to contact me via E-mail ☐ Yes ☐ No

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Details: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## NEXT OF KIN CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Details: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Do you hold any of the below cards? If so please provide details

- ☐ Centrelink Health Care Card  
☐ Centrelink Pension Card  
☐ Centrelink Senior Health Card  
☐ Dept. of Veteran Affairs (DVA) Gold Card
- Card Number : \_\_\_\_\_  
Expiry : \_\_\_\_\_

*I understand that Heidelberg West Medical complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Heidelberg West Medical collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits; inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Heidelberg West Medical to use and disclose my personal information (except when legal obligations must be met).*

Patient Signature: \_\_\_\_\_

How did you hear about us? ☐ Family ☐ Friend ☐ Google ☐ Hotdoc ☐ Health Engine  
☐ Facebook ☐ Instagram ☐ Other: \_\_\_\_\_

Do you know about My Health Record? ☐ Yes ☐ No (If not, please ask our friendly reception staff)

Would you like our Clinical/Admin staff to register you for My Health Record ☐ Yes ☐ No  
(Please ask a form to fill out from Reception)



HEALTH GROUP

Shop 2/15, 15-23 The Mall (1C), Bell Street  
Heidelberg West VIC 3081

P: (+61) 3 9458 1371  
F: (+61) 3 9458 1379  
hwmedical.com.au

NEW PATIENT REGISTRATION FORM

