Medplus
MEDICAL & SKIN CENTRES

PULLENVALE | IPSWICH | ROTHWELL | STRATHPINE | LUTWYCHE

Medplus Pullenvale Pty Ltd
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How did you hear about us? _____

New Patient Registration Form

Title: Mr. Mrs. Miss Ms Dr Master

First Name:_____**Surname:**_____

Preferred Name:_____**Date of Birth:**_____/_____/_____ **Sex:** Male / Female

Address:_____ **Suburb:**_____

Post Code:_____**Postal Address (If different)**_____

Home Phone:_____**Mobile:**_____**Work:**_____

Email Address:_____

Medicare Card Number: _____**Reference Number:** _____ **Expiry Date:** _____/_____/_____

HCC/ DVA / Pensioner Card: _____**Expiry Date:** _____/_____/_____
(Please Circle)
Emergency Contact Name: _____**Relationship:**_____ **Contact Number:** _____

Knowing your cultural background can help us provide health care that meets your individual needs.
Do you identify as an [] Aboriginal [] Torres Strait Islander [] Neither

Country of Birth: _____**Preferred Language:** _____

Do you need an Interpreter? YES / NO if yes, which language: _____

PRACTICE POLICY AGREEMENT

By becoming a patient of Medplus Pullenvale and signing below, I have read and agree to the following:
CONSENT: Medplus Pullenvale located at 9/8 McCaskill Road, Pullenvale Q 4069 collects your personal details and health information to ensure we deliver the best possible health care service. Patients are entitled to access their information at any stage by contacting the practice. Your health information may be disclosed to other organisations over the course of your treatment and these instances will be discussed with you if required. Failure to provide accurate and comprehensive information could negatively affect your healthcare. If you have any concerns regarding your privacy, please contact the practice. Our Practice uses a reminder system to help you maintain your health. The practice may send reminders by post, email, and/or telephone for procedures such as vaccinations, Pap Smears and other health services. Our practice also sends information to the Australian Childhood Immunisation Register (ACIR) and Pap Smear Register (PSR). These registers also send reminders. I understand by indicating signing below that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time verbal or written notification.

[] Tick here if you do not wish to receive communication from us regarding our services.

- **An appointment must be made with a doctor to obtain results, repeat prescriptions or referrals. Results will not be given over the phone.**
- **Doctors at this practice do not routinely prescribe schedule 8 drugs and have a no tolerance policy to doctor shoppers and drug seekers. Doctors have the right to refuse the request of prescription drugs.**
- **This practice has a no-tolerance policy to aggressive or abusive behaviour. Patients who are physically or verbally aggressive to staff will be banned from the practice at the discretion of the doctor or practice manager.**

Name of Patient (please print): _____

Signature: _____ Date: _____