MOORUNDI
Aboriginal Community Controlled Health Service Ltd.

New Patient Registration Form

Moorundi Aboriginal Community Controlled Health Service Ltd. are committed to providing the best care possible, this includes primary and preventative care and chronic disease management. To enable us to carry this out please complete the following form.

PERSONAL DETAILS

NAME	
SURNAME	
DATE OF BIRTH & GENDER	DATE OF BIRTH _____/_____/_____ Place of Birth: _____ Male ❑ Female ❑ Other ❑_____
ADDRESS	_____ SUBURB: POST CODE:
PHONE / MOBILE	
MEDICARE CARD	_____Ref No._____ Expiry _____
CONCESSIONS	Health Care Card ❑_____Expiry_____ Pension Card ❑_____Expiry_____ DVA Card No. _____ Expiry _____
ABORIGINALITY	Are you Aboriginal or Torres Strait Islander? Aboriginal ❑ Torres Strait Islander ❑ Both Aboriginal & Torres Strait Islander ❑ Neither Aboriginal nor Torres Strait Islander ❑
CULTURAL INFORMATION	Cultural Background: _____ Country of Birth: _____ Language: _____
EMERGENCY CONTACT	Name: _____Relationship:_____ Contact numbers _____/_____
ALLERGIES	Nil Known ❑_____ Yes ❑(please list)_____ _____ _____ _____ _____

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NDIS	Are you an NDIS Participant? Yes ❑ No ❑ If yes, is your plan Self-Managed ❑ Plan Managed ❑ Agency Managed ❑ Don't Know ❑

AGED CARE	Do you receive any of the following: **HCP** Yes ❑ No ❑ If yes, what level? 1 ❑ 2 ❑ 3 ❑ 4 ❑ Who is your Provider? **CHSP** Yes ❑ No ❑ Who is your Provider?
PATIENT CONSENTS	Voicemail Messages Yes ❑ No ❑ SMS Reminders Yes ❑ No ❑

PRIVACY AGREEMENT AND PATIENT CONSENT

I hereby acknowledge that Moorundi Aboriginal Community Controlled Health Service Ltd complies with the Privacy Act (1988) and as a part of their privacy policy Moorundi Aboriginal Community Controlled Health Service Ltd. is committed to protecting the privacy and personal information of all patients.

I have read the above and consent to Moorundi Aboriginal Community Controlled Health Service Ltd. collecting, using, storing and disposing of my personal information and authorise the release of relevant information to other health professionals to allow for premium medical care. I agree to be part of the recall register (including State and National registers), to be advised of follow up visits, medical updates and health information. I understand that Moorundi Aboriginal Community Controlled Health Service Ltd. does not disclose my personal details unless legally required. I understand that I can withdraw my consent at any time, and will need to do this in writing.

Signed: _____ Date: _____/_____/_____

I received assistance filling out this form/this form was filled out by someone on my behalf Yes ❑ No ❑

If ticked yes, please fill out the information below:

Person who filled out form _____
Relationship to client _____
Contact number _____