PATIENT REGISTRATION FORM

BONDI WOMEN'S HEALTH

Miss/ Mrs/ Ms/ Dr/ Other _________	______________________ (surname)	______________________ (first & middle name)
Date of Birth: (DD /MM /YYYY) ______/______/________		
Address:		Post code:
Postal address (if different from above):		Post code:

Contact Details	
Home:	Mobile:
Work:	Email: @
Appointment reminders will be sent via SMS 2 days before your scheduled appointment. Please tick box if you **DO NOT** wish to be reminded of your appointment via SMS.	☐
At times, email may be used to communicate with you. Your email address will not be published. Please tick box if you **DO NOT** wish to have email correspondence from us.	☐

Medicare No: __ __ __ __-__ __ __ __ __-__	Ref No:___ (number next to your name)	Expiry Date: ___/___
Health Fund Name:	Membership No:	UPI: (number next to your name)
Occupation:	Language spoken:	

Emergency Contact	
Partner name:	Contact number:
Next of kin (if different to above):	Relationship to you:
	Contact number:

Your General Practitioner /Local Doctor	
Name:	Phone:
Address:	Fax:

Your Referring Doctor (if different from above)	
Name:	Phone:
Address:	Fax:
Correspondence will automatically be sent to your referring doctor and copied to your GP/ local doctor. Please inform your specialist if you do not want correspondence sent.	

How did you hear about us?	☐ GP/Specialist ☐ Friend/Family ☐Google ☐Walked past ☐Other________

Please turn page over↲

PRACTICE INFORMATION

BONDI
WOMEN'S HEALTH

This document is to inform you of the various policies and procedures that may affect you as a patient attending our service. We require you to read and acknowledge that you have read this document prior to attending our practice.

PRIVACY NOTICE

The personal and health information that is provided by you and recorded in your Electronic Health Record will be collected for the purpose of providing you with treatment. Your information is collected and held in accordance with NSW privacy legislation under which you have rights of access and correction. More information about your privacy rights is available on the internet at www.privacy.gov.au.

Your medical record is a permanent legal document and we take its security very seriously. We can, on written request, provide you or a person nominated by you with a copy of your Health Record. For legal reasons, your request must be made in writing, and approved by your treating practitioner.

CONSENT TO RELEASE OF MEDICAL INFORMATION

I give my consent to Bondi Women's Health, or their agent and advisors, to contact medical practitioners or other bodies who I have consulted to obtain health and other information that may be pertinent to my care. I authorize those medical practitioners or bodies to release such information, which my include sensitive health information, to Bondi Women's Health, or their agent and advisors, as my be requested. I understand that unless I advise otherwise, Bondi Women's Health will continue to liaise with the doctors nominated by me on matters related to my ongoing care.

☐ **I have read and understood the above Privacy Policy and release of medical information** ***Initials*________**

CANCELLATION POLICY

SMS reminders will be sent for all scheduled appointment 2 working days prior. If you do not have a mobile phone or elect not to receive an SMS, our practice staff will telephone you on the number/s you have provided. If it is necessary to cancel your scheduled appointment we require that you notify us by 4pm the working day before. This can be done either by responding to the SMS or phoning 1300 188 833. **Any appointment not confirmed by return SMS or phone call by 4pm the working day prior will automatically be cancelled.** Late cancellations will be considered as anyone who cancels their confirmed appointment after 4pm the working day before. A "did not attend" (DNA) is someone who misses a confirmed appointment without cancelling it.

Cancellation fees	Late cancellation (after 4pm the day before)	50% of normal consultation fee will be charged
	Missing a scheduled appointment (DNA)	100% of normal consultation fee will be charged

☐ **I have read and understood the above Cancellation Policy.** ***Initials*__________**

RESEARCH CONSENT

Your information may be used by Bondi Women's Health/or the Royal Hospital for Women, to contact you for research or to evaluate by the way of audit, the service and/or medical treatment that you have received. Any information that you provide for the audit or research purposes will not identify you in any way.

I DO CONSENT to be contacted at a future date for research/ audit purpose.
I DO NOT CONSENT to be contacted at a future date for research/ audit purpose. . ***Initials*__________**

YOUR ACKNOWLEDGEMENT

I have read and understood the above information and policies regarding Bondi Women's Health. I reserve the right to change my consent at any point on written request. I understand that my acknowledgement of above will be recorded in my Electronic Health Record.

________________________ ________________________ ____/____/_____
Print First Name *Print Last Name* *DOB*

____ ____/____/_____
Signature *Today's Date*

Thank you for taking the time to read this information.