# NEW PATIENT REGISTRATION FORM

All fields marked with an asterisk (*) are required.

## PERSONAL DETAILS

Title ○ Miss ○ Ms ○ Mrs ○ Mr ○ Other

First name* Last name*

Preferred name

Which of the following best describes your current gender identity?*

○ Female ○ Male ○ Non binary/gender fluid ○ Rather not specify

○ Different identity

What sex were you assigned at birth (i.e. what was specified on your original birth certificate)?

○ Female ○ Male ○ Rather not specify

What are your pronouns?

○ She/Her ○ He/Him ○ They/Them ○ Rather not specify

○ Other

Date of birth* dd/mm/yyyy

Street address Street address line 2

Suburb Postcode

Mobile phone* Email address*

## EMERGENCY CONTACT INFORMATION

FPV will only contact your nominated next of kin or emergency contact in the event of a significant medical emergency.

**Next of Kin**; First name Last name

Relationship Contact number

**Emergency contact**; First name* Last name*

Relationship* Contact number*

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## HEALTH INITIATIVES

In order to assist us with health initiatives and tailor care.

Do you identify as Aboriginal and/or Torres Strait Islander?

Yes  Please select what you identify as

Aboriginal  Torres Strait Islander  Aboriginal/Torres Strait Islander

No

What is your country of birth?

What is your cultural identity (this may or may not be the same as your country of birth)?

Preferred language spoken

Do you need an interpreter?  Yes  No

Are you a refugee?  Yes  No

## MEDICAL INFORMATION

Do you have any of the following cards?

Medicare card (you do not need to have a Medicare card to access our services)

Card number  Position on the card  Expiry date mm/yyyy

DVA card  Expiry date mm/yyyy

Gold  White

Pension/Health Care card

Card number  Ref  Expiry date dd/mm/yyyy

## COMMUNICATION

FPV may need to contact you if any aspect of your care requires follow-up, as per FPV policies and/or protocols.

I consent to receive SMS appointment reminders and clinical messages relevant to my care*

Yes  No

I consent to receiving a telephone call from an FPV clinician to discuss matters relating to my clinical care

Yes  No

To ensure your privacy, please provide a password. This will be requested before we give any results over the phone.

Your password

I authorise FPV to access my cervical testing history from the National Cervical Screening Registry for the purpose of cervical screening follow up

Yes  No - I understand that by not authorising access to the Registry, I may limit interpretation of cervical screening results by FPV clinical staff

**Privacy and Terms**

We are committed to protecting the confidentiality of your personal information and health records. In submitting this form, you;
1. acknowledge that we, and our service providers, will collect your personal and health information to enable us to provide you with our health services and any related communications (for example, to manage your appointment bookings); and
2. consent to our handling of your personal information in accordance with our Privacy Policy.

Do you agree to the terms?*  I agree  Signature*

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