

REGISTRATION FORM

AIM Health / Melbourne Student Medical Centre



Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other _____

Given Name: _____ Middle Name: _____ Surname: _____

Date of Birth: ____/____/____ Gender: Male ☐ Female ☐ Intersex ☐ Other _____

ATSI: To assist with health initiatives - are you Aboriginal and/or Torres Strait Islander?

No ☐ Yes-Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes-Aboriginal and Torres Strait Islander ☐

Unit No: _____ Street No: _____ Street Name: _____

Town/Suburb: _____ Postcode: _____ Mobile No: _____

Email Address: _____ Home Phone: _____

Medicare Card No: _____ No before your name: _____ Expiry: ____/____/____

Dept. of Veterans' Affairs File No: _____ Gold ☐ White ☐

Concession: Pension ☐ Health Care ☐ Senior Health ☐ Card No: _____ Expiry: ____/____/____

Private Insurance : Allianz ☐ AHM ☐ BUPA ☐ Medibank ☐ NIB ☐ IMAN ☐ Other _____

Policy No: _____ Expiry: ____/____/____ OSHC ☐ OVHC ☐ Other _____

Student No: _____ Expiry: ____/____/____

Emergency Contact Name in Australia: _____ Gender: Male ☐ Female ☐

Relationship: _____ Contact No: _____

Next of Kin Name: _____ Relationship: _____ Contact No: _____

Brief Medical History: Allergy: _____

Family History: _____

Past Medical/Surgical History: _____

Current Medication: _____

Cultural Background: _____ Do you require an interpreter service? No ☐ Yes ☐

Patient Consent (Please read this consent and agreement carefully prior to signing):

- 1) I understand that collecting my personal information and medical history is required to ensure high quality healthcare, accurate Medicare/Insurance billing and referral to other specialists. I agree to let other healthcare providers to access **My Health Record** in the event of an accident or emergency. *(If you do not agree, please notify to the receptionist.)*
- 2) I shall inform AIM Health if there are **any changes to my contact details**, such as address and phone number. If I am unable to be contacted, I understand that I am responsible for any associated consequences.
- 3) I consent for AIM Health to send me reminders via **SMS, phone call, letter or email**.
- 4) I understand that AIM Health **does not** inform results over the phone, by email, fax or post.
- 5) I agree that I need to make an appointment to **physically visit** the doctor to discuss my results, and /or, obtaining a referral, prescription, medical certificate, mental health care plan or EPC, etc.
- 6) I understand that AIM Health requires at least **12 hours' notice** to cancel or reschedule an appointment. Failure to do so may result in a cancellation fee of **\$30**, which needs to be paid within 7 days.
- 7) I am aware that there will be **an administration fee** to transfer/obtain my medical records, which needs to be paid upfront, as per the Australian Health Record Regulation.
- 8) I need to make **a longer appointment** if I have more than one issue or complex health conditions: e.g. TAC or Workcover (not covered by Medicare), referral to allied health providers, EPC referral –as per Medicare requirements under GP Management Plan and Team Care Arrangement.

Signature: _____

Date: _____