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** unless opt-out. (*If you do not agree, please notify 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 for mental health care plan, to allied health providers, EPC referral –as per Medicare requirements under GP Management Plan and Team Care Arrangement.

Signature:____________________ Date:____________________