

REGISTRATION FORM



AIM Health/Melbourne Student Medical Centre

Surname: 姓		First Name: 名	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss 头衔		Date of Birth: 生日	Gender: 性别
Address: 住址			
Suburb: 区		Post Code: 邮编	State: 州
Mobile Phone: 手机号码		Country of birth: 出生国	
Email Address: 邮箱地址			
If you have Medicare 如果您有Medicare :			
Medicare No.卡号:		Reference No.:	Exp过期日:
If you have Concession card 如果您有福利卡 :		<input type="checkbox"/> Pension Card <input type="checkbox"/> Health Care Card <input type="checkbox"/> Senior Health Care Card	
Card No.卡号:		Exp过期日:	
If you do not have Medicare 如果没有Medicare :			
Type保险类型: <input type="checkbox"/> OSHC <input type="checkbox"/> OVHC			
保险公司: <input type="checkbox"/> BUPA <input type="checkbox"/> Allianz <input type="checkbox"/> nib/IMAN <input type="checkbox"/> Medibank/ahm <input type="checkbox"/> CBHS			
Policy No. 保号:		Exp过期日:	
Emergency Contact Name: 在澳紧急联系人姓名		Phone No: 电话	Relationship: 关系
Are you of Aboriginal or Torres Strait Islander? 您是原住民和/或托雷斯海峡岛民吗?		<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> 不是 <input type="checkbox"/> 是 :	

Patient Consent (Please read this consent and agreement carefully prior to signing) 请阅读条款:

- 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 or hospitals.
- 2) I shall inform AIM Health if there are any changes to my contact details, such as address and phone / mobile 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 consent for AIM Health to submit data to diseases registers to assist with preventative health management (e.g. cervical, breast and bowel screening, etc.) and share de-identified information for quality improvement and clinical audit activities purposes.
- 5) I agree that I need to make an appointment to discuss my results, or obtain referrals, prescription, medical certificate, MHCP, EPC, etc.
- 6) I understand that AIM Health requires at least one day 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 / insurance requirements under GP Management, etc.
- 9) I agree to the assignment of the Medicare benefit directly to the provider unless other arrangement on the day.

Signature: _____
签名

Date: _____
日期