



**WEST KENTISH**  
GENERAL PRACTICE

## New Resident Registration Form

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Meercroft:**  Seaview  Oceanview  Park View  Park Avenue  Park Lane

**Karingal:**  South  East  West

**Rubicon Grove:**  Blue Gum  Shea Oak  Blackwood  Tea Tree

**Strathdevon:**  Henley  Roland

**Melaleuca:** \_\_\_\_\_

**Tandara:** \_\_\_\_\_

**Medicare Number:** \_\_\_\_\_ **Expiry:** \_\_\_\_\_

**DVA Card Number:** \_\_\_\_\_

**Pension Concession Card Number:** \_\_\_\_\_

**Ethnicity:**  Australian, non-indigenous  Aboriginal / Torres Strait Islander  Other

**Who was your last GP or GP surgery:** \_\_\_\_\_

**Which pharmacy have you been using:** \_\_\_\_\_

**Have you completed any of the following?**

- Advanced Care Directive
- Power of Attorney
- Guardianship Order

**Who is your next of kin or responsible person and how do we contact them if needed?**

\_\_\_\_\_

**Who is your emergency contact and how do we contact them if needed?**

\_\_\_\_\_

I give permission for West Kentish General Practice staff to hold my medical information, coordinate my care, and share information with other healthcare providers when medically appropriate, including by phone, email and text message.

I give permission for West Kentish General Practice staff to coordinate my care by phone or video link and for Telehealth appointments out of hours if this is needed for my care, even if I am unable to participate directly in the conversation (eg too unwell), and to bill Medicare for these consultations

I understand that my care will be bulk billed through Medicare, and if any service is not covered, I will be informed beforehand.

**On registering with WKGP I agree to:**

- Also register with MyMedicare
- Complete an Advance Care Directive
- Be seen by a locum doctor if my usual doctor is on holiday or unavailable

**Signed:** \_\_\_\_\_ **Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Note: If the person lacks capacity to sign then the above statement is made on their behalf and signed by next of kin or person responsible, or if unable to sign because of physical issues they can be witnessed indicating their compliance and the form signed by next of kin, person responsible or RACF facility registered nurse.

**Note (Important):**

If I do not wish to register with WKGP, or I wish to seek care elsewhere I will email [admin@wkgp.com.au](mailto:admin@wkgp.com.au) or phone 0437 034 714 as soon as I have registered with an alternative doctor.

**Please email this form to [admin@wkgp.com](mailto:admin@wkgp.com) once completed.**

## NEW RESIDENT BACKGROUND INFORMATION

**Name:** ..... **DOB:** .....

**Past occupations:** .....

**Smoking:**

Nonsmoker

Smoker                      Age started: .....      Age stopped: .....

Current smoker          Cigs/day: .....

**Alcohol:**

Nil                      Occasional                      Frequent/daily

Previous heavy intake      Yes/No

**Illnesses in family**

Parents: illnesses, age at death, cause of death

.....  
.....

Brothers/sisters: Illnesses, age at death, cause of death

.....  
.....

Other family members' illnesses, if relevant:

.....  
.....

Are you seeing any specialists in clinics, or waiting for any reviews, investigations or procedures?

This includes things like ophthalmology (eyes), medical clinics, memory clinics, surgical waiting lists, colonoscopy, diabetes clinics, heart, lung or kidney specialists and any others.

Please list below, if relevant:

.....  
.....

## TRANSFER OF RECORDS FORM

### PREVIOUS PRACTICE

Dear Dr: .....

Address: .....

Email: ..... Phone: .....

### PATIENT CONSENT

I .....

Herby consent to release my full medical records to:

West Kentish General Practice  
628 West Kentish Road  
West Kentish TAS 7306  
Phone: 0437 034 714  
Email: admin@wkgp.com.au

### PATIENT DETAILS

Name: .....

DOB: .....

Address:  
.....

Previous Address: .....

**Signature of patient or guardian:** ..... **Date:** .....

\*\* We prefer an electronic copy of the records in XML format.

\*\*Postal Address: 286 Old Paradise Road, Sheffield TAS 7306



# Registration Form

MyMedicare is a voluntary patient registration model. MyMedicare aims to formalise the relationship between patients, their general practice, general practitioner (GP) and primary care teams.

MyMedicare patients and their usual GP and practice will have access to new benefits to help deliver more of the care patients need, improving health outcomes.

Your completed MyMedicare Registration Form should be provided to your preferred general practice to complete your registration process.

## Patient Details

### Family name

### First given name

### Second given name

### Date of Birth

(dd)	(mm)	(yyyy)
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### Medicare Number or DVA File Number

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### Medicare IRN

## Practice and provider details

### Practice name and practice address


Name of preferred GP \_\_\_\_\_

## By signing this form I agree to the following:

1. I understand that registering in MyMedicare is voluntary.
2. I consider this practice to be my regular primary health care provider.
3. I understand that I can only be registered with one practice at a time. By submitting this form, any existing registration in MyMedicare will be withdrawn, and my previous practice and provider will automatically be notified that I am no longer registered with them under MyMedicare.
4. I understand that I will remain registered unless:
  - o I register with a different practice.
  - o I request my GP/practice or Services Australia to withdraw my registration.
  - o My GP or practice decides to withdraw my registration.
5. I understand that there is no cost to register in MyMedicare.
6. I declare I have read and understand the MyMedicare Privacy Notice and consent to my personal information being collected, used and disclosed by the relevant agencies such as Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and, where applicable, the Department of Veterans' Affairs as specified in the MyMedicare Privacy Notice (a link to this notice is provided in the Privacy Statement at the bottom of this form).

Full name of individual providing consent (patient, patient's guardian/attorney or parent if required)	
Signature	Date

If a parent or guardian has completed this form on behalf of a patient aged 14-17, please confirm the patient is aware of this registration and provided informed consent.  Yes

Consent for MyMedicare registration for patients under 14 years of age must be provided by the patient's parent or legal guardian.

Patients aged 14-17 years must provide their consent to register for MyMedicare.

- A parent or guardian of a patient aged 14-17 years may complete the Registration Form if the 14-17 year old is aware of the registration and has provided their consent for this person to act on their behalf.

For a patient 14 years or older, who lacks capacity to make decisions for themselves, consent for the MyMedicare registration will need to be provided by an individual who is authorised to act on the patient's behalf.

**Office use only**

Provider Number of preferred GP \_\_\_\_\_

**Please select a box to confirm the patient's eligibility**

- The patient has received 2 or more face-to-face MBS services with the practice in the previous 24 months
- The patient meets the reduced eligibility criteria of at least one or more face-to-face MBS services with the practice in the previous 24 months and the practice is located in MMM6-7

**The patient meets one of the exemption criteria:**

- Children under 18 years whose parent is already registered at this practice
- Parents of a child under 18 years who is already registered at this practice
- Patient is following a GP they are registered with to this practice
- Patient experiencing family and domestic violence
- Patient experiencing homelessness

The practice will retain a copy of this Registration Form in the patient's clinical records, for compliance of record keeping obligations in accordance with Federal, State and Territory legislation applicable to their practice.

**Privacy Statement**

The law regulates how Services Australia, the Department of Health and Aged Care, the Australian Digital Health Agency and the Department of Veterans' Affairs may handle your personal information. Services Australia is collecting your personal information to assess your eligibility for MyMedicare and provide services to you and payments linked to your provider as a result of your MyMedicare registration. Your information will only be shared with relevant government agencies such as the Department of Health and Aged Care, Australian Digital Health Agency and the Department of Veterans' Affairs, where you have agreed, or where the law allows or requires it. The MyMedicare Privacy Notice describes how your information will be managed consistent with our obligations under the *Privacy Act 1988* and the *Australian Privacy Principles*. The notice can be found at <https://www.health.gov.au/resources/publications/mymedicare-privacy-notice>

You can also read the:

- Services Australia privacy policy at: [www.servicesaustralia.gov.au/privacy](http://www.servicesaustralia.gov.au/privacy)
- Department of Health and Aged Care privacy policy at: <https://www.health.gov.au/resources/publications/privacy-policy>
- Australian Digital Health Agency privacy policy at: <https://www.myhealthrecord.gov.au/about/privacy-policy>, and
- Department of Veterans' Affairs privacy policy at: <https://www.dva.gov.au/privacy-policy>.