



Patient Details Update Form



We update patient records to keep them accurate and ensure you receive quality care. Please take a moment to complete this form and if you need any help, our team will be happy to assist you.


Instructions:


1. Please complete all required fields (marked with an asterisk*).
2. Please tick (✓) or mark (✗) in the for multiple-choice questions.



Patient Details


 **First name*** _____
  **Last name*** _____

 **Preferred name** _____
  **Date of birth*** ____ / ____ / ____


 **Birth sex (required for Medicare)***
 Female
 Male
 Other


 **Email*** _____

 **Mobile*** _____
  **Home phone** _____

 **Address*** _____



Suburb* _____ **Post code*** _____ **State*** _____



 **What is your country of birth?** _____

 **Do you identify as Aboriginal or Torres Strait Islander?***

Aboriginal
 Torres Strait Islander
 Both
 No



Emergency Contact



 **First name*** _____
  **Last name*** _____

 **Contact number*** _____
  **Relationship to you*** _____


Next of Kin

Tick if same as Emergency Contact or complete below

 **First name** _____
  **Last name** _____

 **Contact number** _____
  **Relationship to you** _____

Card Details

 **Do you have a Medicare Card?***
 Yes
 No
 If yes, please provide your details:

Card number* _____ **Reference No.*** _____ **Expiry date*** ____ / ____

 **Do you have a Concession Card?** Yes No *If yes, please provide your details:*

Card Type: Aged Pension Card Health Care Card Disability Pension Card
 Carer Pension Card Newstart

Card number _____ **Expiry date** ____ / ____

 **Do you have a DVA Card?** Yes No *If yes, please provide your details:*

Card number _____ **Expiry date** ____ / ____

Communication Consent

Your doctor or our team at Signal Health Newton may contact you via SMS and/or email with important healthcare information, including:

- Appointment reminders
- Clinical information (e.g., test results or follow-up instructions)
- Health reminders from your doctor (e.g., routine screenings, vaccinations, or chronic disease management)

If you choose to opt out of these communications, you will not receive appointment reminders, test result notifications, or health reminders from your doctor or our team via SMS or email.

You can update or revoke your consent at any time by notifying our admin team.

I consent to receiving SMS reminders, messages, and emails as described above* Yes No

Would you like us to register your provided email for our website to receive emails about our practice news and updates?* Yes No

Authorised Contact/s for Clinical Information

We are committed to protecting the confidentiality and privacy of your personal health information. In accordance with our privacy policies and relevant regulations, we will only disclose your clinical information directly to you or to another healthcare provider who is involved in your care (such as a specialist to whom you have been referred).

If you would like to authorise a specific family member or contact person to receive and discuss your clinical information on your behalf - including appointment details, pathology, radiology, or other test results - please authorise the below. *Please note that if you don't provide this authorisation, we will be unable to share your personal health information with anyone else, including family members or friends, unless we receive your consent at a later time.*

Would you like to authorise a family member or contact person to discuss your clinical information?*

Yes No *If yes, please provide details below (you can fill out 1, 2 or 3 authorised contacts):*

 **Authorised Contact 1: Name** _____

 **Contact number** _____  **Relationship to you** _____

 **Authorised Contact 2: Name** _____

 **Contact number** _____  **Relationship to you** _____

 **Authorised Contact 3: Name** _____

 **Contact number** _____  **Relationship to you** _____

MyMedicare Registration

MyMedicare is a voluntary patient registration model designed to strengthen the connection between you, your general practitioner (GP), and your primary care team. By registering, you formalise your relationship with your usual GP and practice, ensuring better continuity of care.

As a MyMedicare patient, you and your GP will gain access to new benefits designed to enhance your healthcare experience and support better health outcomes. This means more personalised care, improved access to services, and a stronger partnership in managing your health.

By signing this form, I agree to the following:

- I understand that registering in MyMedicare is voluntary.
- I consider this Practice to be my regular primary health care provider.
- 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.
- I understand that I will remain registered unless: I register with a different Practice. I request my GP/Practice or Services Australia to withdraw my registration. My GP or Practice decides to withdraw my registration.
- I understand that there is no cost to register in MyMedicare.
- 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.

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.

Would you like to register for MyMedicare to access new healthcare benefits?*


Yes No *If yes, please select your preferred GP below*


 **Select the name of your preferred GP for MyMedicare (only one can be chosen):***

- Dr. Joe Alvaro Dr. Simon Hayward Dr. Andrew Kellie
 Dr. Maria Sauchelli Dr. Ellen Stamati Dr. Michael Menezes

Who is completing this form?*

I am the patient I am the patient's parent, legal guardian or substitute decision-maker

 **Full Name:** _____

 **Signature:** _____ **Date:** ____ / ____ / ____

Thank you for helping us keep your details up to date