NEW PATIENT FORM

PERSONAL DETAILS

DR/MRS/MS/MST/MISS/MR

GENDER: ……

SURNAME:……. …… **GIVEN NAMES**:……

D.O.B:……..

ADDRESS:……..

POST CODE:……

PHONE: (H)…….. ……. (M):……

EMAIL ADDRESS:……..

NEXT OF KIN: In case of emergency, it is important for us to be able to contact your next-of-kin to notify them of your whereabouts and anticipated management.

NEXT OF KIN:…… Relationship:……

PHONE No's: (H):…… (M)……

NEXT OF KIN:……. Relationship:…….

PHONE No's: (H):…… (M)…….

CULTURAL INFORMATION

Aboriginal or Torres Strait Islander Yes / No

Country of Birth: …….....

Is English your first language Yes / No Preferred Language: ……..

Occupation…….

MEDICARE

NO:…….. Ref No: …… Expiry Date: …….

PENSION/ HEALTHCARE CARD

NO:…….. ……. Expiry Date: ……

DVA CARD HOLDERS

DVA Number: …… Card Colour: ……

CONSENTS - In keeping with the Privacy Act Laws proclaimed in 2001, we require your written consent in regard to the following.

Please circle Yes or No

I give consent for Medical information to be obtained by my doctor for the purpose of my medical treatment and passed on to third parties eg Specialists for the purpose of further treatment.

Yes/No

This practice uses a reminder system to improve the quality of your health care, and send out reminders for preventative health care, ie immunisations, mammograms, prostate checks, pap smears, cholesterol checks etc.

I give consent for medical reminder letters to be sent to me via my preferred contact.

SMS Email Letter **Yes/No**

I give consent to be registered with the National Registration **Yes / No**

I give consent for my contact details to be obtained for the purpose of contacting me regarding medical matters or appointments. **Yes / No**

I give consent for my information held by the practice, to be used in research projects to improve healthcare in the community; however this information will not include data that can identify me.

Yes / No

I give consent for SMS reminders to be sent on my mobile prior to my appointment the next day

Yes / No

I give consent to release Results to my designated relative/carer.

Yes / No

Relative/Carer Name:…….

PRIVACY:
Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times in accordance with privacy laws, and to ensure that this information is only available to authorized people.

I acknowledge that the information provided on this registration form is true and accurate.

Signature of patient(or parent or guardian): **……**

Date: …….

Print Name: ……..