New Patient Registration and Consent Form

Full name: Mstr/Mr/Mrs/Ms/Miss/Dr **Please Circle**

First Name: _____ **Surname:** _____

Date of Birth:___/____/_____

Please Circle: Aboriginal**/**Torres Strait Islander**/**Aboriginal and Torres Strait Islander**/**Neither

NCACH (Aboriginal) No._____

Medicare No: _____Ref no**:**_____(next to name) Exp_____

DVA Number No: _____Exp_____

Health Care Card No: _____Exp_____

Pension Card No: _____Exp_____

_____

Address:(NOT .P.O.BOX):_____**Suburb:**_____

Postcode:_____ **Phone:** _____ **Mobile:** _____

Email Address: _____

Patient's Marital Status: _____ **Occupation:** _____ **Country of Birth:** _____

Next of Kin:_____ **Relationship:**_____ **Phone:** _____

Emergency Contact Person (if different): _____**Relationship:** _____

Contact Phone No: _____ **Mobile No:** _____

_____

Please tick if you DO NOT want to get an SMS for recalls and reminders ☐

I give permission to register with Medicare for the purpose of validating Medicare No & Item no to bulkbill the consult. This Medical Practice collects information for the primary purpose of providing quality healthcare. We require your personal details and full medical history to allow us to properly assess, diagnose, treat and advise on all your health needs. By signing this document, you are giving permission for your health information to be shared with others involved in your health care, such as treating doctors and specialists within or outside the practice. You are also giving consent to provide de-identified information for quality improvement and research projects. This practice participates in National and State recall and reminder systems.

Signature_____ **Parent/Guardian** (if you are under 18 years)_____

How Did you hear about us? Website ☐ Google ☐ Facebook ☐ Word of Mouth ☐ Health Professional ☐

Family/Friend ☐ School ☐ Walking Past ☐ Local Paper ☐ Business Network ☐ Community centre ☐ Pharmacy ☐