

NEW PATIENT FORM

We need this information to provide you with the best quality of care. Our practice follows the guidelines of The Royal Australian College of General Practitioners handbook for the management of health information in private medical practice. This means that your personal health information is kept private and secure, as required by federal and state privacy laws.

DETAILS: Title _____ First Name _____ Surname _____

Date of birth ____/____/____ Male Female

Medicare Number _____/____ Expiry date _____

Do you have a Pension Card Health Care Card Veteran Affairs Card

Card Number _____ Expiry date _____

Private Health Fund Yes No Basic Intermediate Top

Home Address: _____ Suburb / Postcode _____

Phone: (h) _____ (w) _____ (m) _____

Email: _____ SMS Appointment Reminder: Yes No

Marital Status Single Married De facto Separated Divorced Widowed

Occupation _____ Country of birth _____

Next of Kin

Name _____ Relationship to you _____

Phone: (h) _____ (w) _____ (m) _____

Emergency Contact - If different to Next of Kin, please complete below details

Name _____ Relationship to you _____

Phone: (h) _____ (w) _____ (m) _____

Are you of Aboriginal or Torres Strait Islander origin Yes No

Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

How did you hear about our practice?

Recommendation by: Family /friends Chemist Specialist _____
 Signage Mail out Internet
 Local paper Yellow pages Other please specify _____

Privacy Patient Information

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

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