New Patient Registration Form

Contact Details/Personal			
Please Circle	Mr Mrs Ms Miss Mast Dr		
Full Name		Gender	
Address		Date of Birth	
		Home Telephone	
		Work Telephone	
Postal Address	Same as above ☐		
Mobile Telephone	I consent to be contacted* by SMS on this number: Yes☐ No☐		
Email	I consent to be contacted* by email at this address: Yes☐ No☐		
Next of Kin	Name: Tel: Relationship:		
Emergency Contact	Name: Tel: Relationship:		
Cultural Background	Aboriginal ☐ Torres strait Islander☐ Australian☐ Other-Please specify		
Occupation		Full time ☐	Part time☐

Other Details	
Referring GP	Name: Phone:
	Address:

Medicare & health Fund/Pension/Veterans Affairs/Workcover		
Medicare Number	Ref:	Expiry Date:
Veterans Affairs Card Yes ☐ No ☐	Gold White Yellow	**Dept. of Veterans Affairs Number:**
Health Fund Name	**Membership Number:**	
Health Care Card Number	**Expiry Date:**	
Pension Card Number	**Expiry Date:**	
Is this a Workcover Claim?	Yes ☐ No☐ **Claim Number:**	**Insurer Name:**
Is this a Dept. Of Defence Claim?	Yes☐ No☐	

Allergies
Please record any allergies or sensitivities below

Patient Consent
By signing below, I confirm that: I give my consent for this practice to collect, store, and manage my personal and health information in accordance with the Privacy Act 1988. I understand that this information may be shared with other healthcare providers involved in my care, when necessary, for my ongoing treatment and wellbeing. I consent for health practitioner to use artificial intelligence software to help transcribe clinical notes I consent to being contacted by the practice regarding my healthcare (e.g. appointment reminders, test results) via phone, SMS, or email. I understand that I can withdraw or update my consent at any time by notifying the practice in writing. _____

Signature	
Signature	
Name	
Date	