**New Patient Information Form**

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. **Could you please assist us by completing the following:**

|  |  |
| --- | --- |
| **Title** | 🞏 Mr 🞏 Mrs 🞏 Ms 🞏 Miss 🞏 Mstr 🞏 Other\_\_\_\_\_\_ |
| **Surname** |  |
| **First Name** |  |
| **Preferred Name** |  |
| **Date of Birth** |  |
| **Gender** | 🞏 Male 🞏 Female 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Street Address** |  |
| **Suburb and Post Code** |  |
| **Home Phone** |  |
| **Work Phone** |  |
| **Mobile Phone** |  |
| **Email** |  |
|  |  |
| **Medicare Card Number** | #: |
|  | Ref No:  | Expiry: |
| 🞏 **DVA Gold** 🞏  **DVA White** (Please tick which if relevant) | #: | Expiry: |
| **Pension Number** | #: | Expiry: |
| **Health Care Card Number** | #: | Expiry: |
| **Private Health Cover** | Name:  | #: |
| **Please turn over to page 2…** |
|  |  |
| **Next of Kin**  | Name: |
|  | Telephone: |
|  | Relationship: |
| **Emergency Contact** | 🞏 Same as Above |
|  | Name: |
|  | Telephone: |
|  | Relationship: |
| **Your Occupation** |  |

**Reminder Systems**

|  |  |
| --- | --- |
| **Do you consent to receive SMS reminders, messages and emails regarding your health, for example, appointment and immunisation reminders, recalls for results, etc?** | 🞏 Yes 🞏 No |
| **Cultural Background** |
| **To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?** | 🞏 No🞏 Yes - Aboriginal🞏 Yes - Torres Strait Islander🞏 Yes – Aboriginal & Torres Strait Islander |
| **Were you born in Australia?** | 🞏 Yes 🞏 No |
| If you were NOT born in Australia, where were you born? |  |
| **What is your ethnicity?** |  |
| **Do you require an interpreting service for your consultations?** | 🞏 Yes 🞏 No |
| If YES, what is your preferred language? |  |

**PLEASE RETURN THIS FORM TO RECEPTION ONCE COMPLETED**

**OFFICE USE ONLY**

**INITIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE ENTERED: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**