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:** _____/_____/_____