NEW PATIENT INFORMATION FORM

Please complete **both sides** of the form in capital letters

We are committed to providing our patients with the best care. Please assist us in doing so by completing your new patient record form:

CONTACT INFORMATION

Title: _____ Given Names: _____ Surname: _____

Preferred Name: _____ Date of Birth: ____/ ____/ ____ Gender: _____

Residential Address: _____

Suburb: _____ Postcode: _____

Postal Address: (*if different from above*): _____

Suburb: _____ Postcode: _____

Telephone: (Home) _____ (Work) _ (Mobile) _____

Please tick preferred phone number for test results/surgery phone calls ☐ HOME ☐ WORK ☐ MOBILE

In addition to other communications we may send you from time to time, we may send you the following types of communications:

1. ***appointment reminders** – notifications to you to remind you of upcoming appointment dates with the practice as well as allowing you to confirm your appointment;*
2. ***clinical reminders** - notifications to you to remind you to contact the practice to arrange appointments for regular clinical check-ups, medical procedures, immunisations due;*
3. ***clinical communications** - communications to you about your clinical care at the practice such as returned pathology results or clinical messages from the medical practitioner; and*
4. ***health awareness** – communications to you in relation to general health care information and health care services provided by this general practice including notification about changes to our clinic opening hours, and information about health care services provided by this general practice.*

Do you consent to receiving reminders via SMS? ☐ YES ☐ NO
(If you have an appointment, you will receive the reminder the day before)

Email Address: _____ Occupation: _____

NEXT OF KIN

Full Name: _____ Relationship to you: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

EMERGENCY CONTACT | *Tick if same as next of kin* ☐

Full Name: _____ Relationship to you: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

CULTURAL IDENTITY

To assist with health initiatives – are you Aboriginal and/or Torres Strait Islander?:

☐ NO ☐ YES – Aboriginal ☐ YES – Torres Strait Islander ☐ YES – Aboriginal and Torres Strait Islander

As Australia is a multicultural society, and to tailor appropriate care, encourage understanding and appreciation between people from different nationalities and cultures – do you identify as someone from a culturally and/or linguistic diverse background?

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MEDICARE DETAILS

Medicare Card No: __ __ __ __ __ __ __ __ __ __ Ref No:(on left near name) __ Expiry date ____/ ____

DVA PATIENTS

Card Number: __ __ __ __ __ __ __ __ __ __ Expiry date ____/ ____ Gold / White / Orange

OTHER Pensioner Card / Health Care Card / Commonwealth Seniors Health Card Number

Card Number: _____ Expiry date ____/ ____

☐ NO

☐ YES – please elaborate _____

ALLERGIES Do you have any allergies? YES ☐ NO ☐

PRODUCT	REACTION	SEVERITY

HEIGHT AND WEIGHT

If know your height and weight please state below to allow us to get to the issue that brought you in faster and provide you with the best suited care. If it has been a while since these were last measured or you aren't sure what they are please inform the reception and you will be put you through to see the nurse prior to your first appointment.

Height: (cm) _____ Weight: (kg) _____

IDENTIFICATION Medicare and non-Medicare holders, please provide identification

Administration use only – identification has been sighted. Administration signature _____

Medicare card ☐ Other ☐

PATIENT CONSENT AND DECLARATION

Please read the Patient Consent and Privacy document and the below information prior to signing. For a more detail version read the copy at the fron of the new patient form clip board.

- I acknowledge that West End Medical charges a fee for non-attendance and late cancellations of less than 2 hours' notice. Nonpayment of accounts may incur further costs if not paid within 7 days.
- I acknowledge that West End Medical is a Private Billing Practice.
- I am responsible for all accounts of any children under the age of 16 years who I am listed as their next of kin.
- I have read the Patient Consent and Privacy document and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out above, my further consent will be obtained.
- I give permission for my personal information to be collected, used and disclosed as described above. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Patient or Parent/Guardian Signature: _____ Date: _____

If patient is under the age of 16, please list the person responsible for payment of the account

Guardian's name: _____ Contact Number: _____

If you are experiencing acute symptoms (e.g. a lot of pain, vomiting) or you think you (or your child) may have an infectious disease (e.g. measles), please tell the receptionist immediately so we can provide you with the appropriate care.

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