

# 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. To do this, it is essential that your health record contains complete and accurate information. Please assist us 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

Do you consent to receiving appointment 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?

NO

YES – please elaborate \_\_\_\_\_

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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 \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_

**ALLERGIES** Do you have any allergies?

YES  NO

PRODUCT	REACTION	SEVERITY

## 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.

- I am in receipt of a West Perth Medical Centre Practice Information Sheet.
- I acknowledge that West Perth Medical Centre 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 Perth Medical Centre 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 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.**