NEW PATIENT REGISTRATION FORM – ADULT

SECTION A – PERSONAL DETAILS

Title | **Family name** | **First name** | **Middle name** | **Preferred name**

D.O.B **Gender identity** ☐ Male ☐ Female ☐ Other

Ethnicity

☐ Australian, non-indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

Other cultural background (e.g. Mediterranean, Asian, African)

Is English your first language? ☐ **Yes** ☐ **No**

Do you require an interpreter? ☐ **Yes** ☐ **No**

Please specify language.

Home address **Postcode**

Postal address **Postcode**

Home phone **Mobile phone** **Work phone**

Email

Occupation

Next of kin

Relationship to you

Phone number **Mobile number**

Emergency contact

Relationship to you

Phone number **Mobile number**

Medicare card number **Ref. number** **Expiry**

Pensioner concession card **Expiry**

Health Care card **Expiry**

Veteran's Affairs card **Type** Gold | White

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SECTION B – CONSENT

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, cervical screening tests (Pap test) and other health reviews.

I consent to receiving appointment reminders via SMS ☐ **Yes** ☐ **No**

I consent to being contacted with clinical reminders ☐ **Yes** ☐ **No**

I consent to receiving health awareness information ☐ **Yes** ☐ **No**

Are we able to leave a confidential message for you regarding results, recall, or confirming/changing appointments on? (please circle your preference)

Mobile Yes | No **Home** Yes | No **Work** Yes | No

I authorise the following person to take messages regarding a recall, reminder or change of appointment on my behalf:

Name

Relationship to you

Phone number **Mobile number**

☐ **I have been given a copy of 'Westside Medical Centre Practice Information' sheet (take time to read)**

☐ **I understand that Westside Medical Centre is NOT a bulk-billing practice. Payment is required on the day of consult. If you hold a current Pension Card you will be bulk-billed.**

Privacy

It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff. Patient information may have to be disclosed to other doctors, nurses and medical technicians so that proper health care is not compromised. You can assist in maintaining the accuracy of your information by advising the practice of any changes to your personal contact details.

Is there a Guardianship Order in place for this patient? ☐ Yes ☐ No

Guardian's name

Guardian's phone number

Please supply a copy of the Guardianship Order

Signature of patient or guardian **Date**