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 contains complete and accurate information. Please assist us by completing your new patient record form: **BULK BILLING CLINIC**

Contact Information	
Gender:	
Title:	
Surname:	
First Name:	
Date of Birth:	
Street Address:	
Postal Address: *(if different to above)*	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	
Marital Status:	
Country of Birth:	
Occupation:	

Emergency Contact Details	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Next of Kin	
Name:	Relationship to you:
Home Phone:	
Mobile Phone:	

Healthcare Identifiers

Medicare Number: _____ Ref: _____ Expiry: ___/_____

Dept. of Veterans' Affairs File Number: _____ ☐ Gold ☐ White

CIRCLE Concession (Pension/Health Care) Card Number: _____ Expiry: ___/ ___/_____

Cultural Identity

New Patient Information Form

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 genuinely 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_____

If yes, do you require an interpreter service? ☐ No ☐ Yes

Your Health Information

ALLERGY INFORMATION - Do you have any allergies or are you sensitive to drugs or dressings?

☐ No

☐ Yes – provide details:

Patient Consent

- *A SMS reminder service via Health Engine the day prior to your appointment*
- *I consent to the use of my personal health information being shared by Urangan Medical Centre and other health care providers involved in my medical treatment and health care within this centre including "My Health Record".*
- *I consent to the disclosure of my personal health information by the above-named practice to other health care providers involved directly or indirectly with my personal health care or medical treatment including "My Health Records".*
- *I consent that my personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.*

Patient name: (please print) _____

Signature: _____Date:_____

If not patient signing - your name (please print)_____

Your relationship to patient (e.g. Mother, Father, guardian)_____

PRACTICE USE ONLY:

Witnessed by: (staff signature)_____