New Patient Registration

Please Circle: Mr / Mrs/ Ms/ Miss/ Mast / Other

Surname: ……

First Name: ……

Gender: Male / Female / Other……

DOB: ……/……/……

If patient is a child: Name of Parent / Guardian:

……

Address: ……

Postal (if different)……

Suburb:……

Postcode:……

Home Telephone:……

Work Telephone: ……

Mobile: ……

Consent to SMS reminders: Yes / No

Ethnicity: ……

Aboriginal & Torres Strait Islander: Yes / No

Torres Strait Islander Yes / No

Aboriginal Yes / No

Occupation: ……

Medicare Card No: ……

Exp Date: ……/……/**Ref No**: ……

Do any of these cards apply? (Please circle)

Vet Affairs / Pension / Healthcare

Card No: ……

Exp Date: ……/……/……

Private Health Insurance: YES/ NO If yes

Fund…… Member No: ……

Next of Kin Contact Details:

Name: ……

Tel:……

Relationship**:** ……

Emergency Contact Details:

Name: ……

Tel:……

Relationship**:** ……

Transfer of Health Information

You may have previously consulted with a GP at another practice. The Health Information held by that GP may assist with your future healthcare needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask at reception for this to be arranged.

Consult Fees

Payment is required in full at time of consultation. Patients are liable for all Workover and TAC claims. Accounts referred to a debt collection or solicitor will incur a debt collection fee.

By signing this form you understand all procedures of the practice and agree to pay all accounts within the practice's specified time period.

Declaration

I agree that all information I have provided is true and correct to the best of my knowledge.

Signed: ……

Date: ……/……/……

***OFP patients are placed on a Recall / Reminder Systems for all Health Checks and Assessments and Care Plans. If you do not wish to participate please advise us.