New Patient Information & Consent Form

(To be completed by all individuals 14 years and older)

Title: First Name(s): Middle Name: Surname:

Date of Birth:

Medicare Card Number (**10** digits): Ref No: Expiry Date:

DVA Number: Expiry Date:

Pension Number: Expiry Date:

Government Health Care Card: Expiry Date:

==========

Personal Contact Information

Street Address:

Suburb: Post Code:

Home Phone: Mobile:

Work: Email:

==========

Next of Kin

Name: Relationship to You:

Contact Number:

==========

Emergency Contact

Same as Next of Kin ❑

Name: Relationship to You:

Contact number:

Do you give consent for the above person to be contacted by Hunters Hill Medical Practice in an emergency or in the event that you cannot be contacted? Yes ❑ No ❑

Please Turn Over

==========

Further Information

Are you of Aboriginal or Torres Strait Islander descent? **Yes** ❑ **No** ❑
Aboriginal ❑ Torres Strait Islander ❑

Do you have any cultural, religious or other background information you would like your doctor to be aware of?

Do you require a translator? Yes ❑ No ❑

How did you hear about us?

HHMP Website ❑ Other online ❑ Street Signage ❑ Other Health Care Provider(s) ❑

Friends/Family ❑ Other ❑ (*Please specify*)

==========

What is your preferred method for this practice to contact you:

Phone call ❑
SMS ❑
Email ❑
Letter ❑

==========

PLEASE PROVIDE A CURRENT PHOTO ID AND YOUR MEDICARE CARD WITH THIS FORM.

==========

Privacy Policy

(Available at Reception and upon request)

I have read and understood the Privacy Policy and agree for correspondence to be sent to other clinicians involved in my care. ❑

Signature: Date:

Thank you for completing this form. Current and accurate information enables the Practice to keep your records up to date and provide quality care.