



**New Patient Details/Consent**

Title: (please circle) Mr Mrs Ms Miss Mast Dr Prof

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Preferred Name (if any): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

**Do you identify as someone from a culturally and/or linguistic diverse back ground?**

**Yes – Please give details** \_\_\_\_\_

**To assist us with health initiatives – are you Aboriginal – Yes / No or Torres Strait Islander – Yes / No**

Address: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_ Mobile No: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

Medicare No: \_\_\_\_\_ Patient: 1 2 3 4 5 6 7 8 Expiry Date: \_\_\_\_/\_\_\_\_

Healthcare Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Pension Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Veteran Affairs Number: \_\_\_\_\_ Type: (please circle) Gold White Other

Patients Occupation: \_\_\_\_\_

Emergency Contact/  
Next of Kin: First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

As Above or Address: \_\_\_\_\_

Suburb \_\_\_\_\_ Post Code: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Contact Phone No: \_\_\_\_\_ Mobile: \_\_\_\_\_

**CONSENT FOR USE AND DISCLOSURE OR PERSONAL HEALTH INFORMATION:**

I consent to the use of my personal health information by the above-named practice and other health providers involved in my medical treatment and health care. I consent to the disclosure of my personal health information by the above named practice/clinic to other health providers directly involved in my personal healthcare or medical treatment.

I consent to recall and reminders being sent to the email address or phone numbers that I have provided.

I understand that the Doctors within the Practice and Clinic are qualified General Practitioners.

**Patients Signature or Parent / Guardian** (if child is a minor) \_\_\_\_\_