Chhaya Medical Services Pty Ltd T/As

Flagstone Pioneer Health

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) _______________________________________