# NEW PATIENT FORM

**PLEASE COMPLETE BOTH SIDES OF THIS PATIENT INFORMATION FORM**

**SURNAME:_____ GIVEN NAME:_____**

**PREFERRED NAME:_____ DATE OF BIRTH:_____**

**MS/MRS/MR/DR/MISS MALE/FEMALE/OTHER HE/HIM SHE/HER THEY/THEM** (PLEASE CIRCLE)

**COUNTRY OF BIRTH:_____ MARITAL STATUS:_____**

**STREET ADDRESS:_____**

**SUBURB:_____ POSTCODE:_____**

**MOBILE:_____ HOME PHONE:_____ WORK:_____**

**EMAIL:_____ DO YOU IDENTIFY AS ABORIGINAL OR TSI: YES/NO**

**MEDICARE NUMBER:_____ REF:_____ EXPIRY:_____/_____**

**DVA NUMBER:_____ CARD COLOUR:_____**

**HCC/PENSION NUMBER:_____ EXPIRY:_____/_____**

**PRIVATE HEALTH DETAILS:_____ MEMBER NUMBER:_____**

**NEXT OF KIN:_____ RELATIONSHIP:_____**

**ADDRESS:_____**

**MOBILE:_____ HOME PHONE:_____**

**EMERGENCY CONTACT:_____ RELATIONSHIP:_____**

**ADDRESS:_____**

**MOBILE:_____HOME PHONE:_____**

**DO YOU REQUIRE AN INTERPRETER: YES/NO** (PLEASE CIRCLE)

**CONSENT TO CONTACT BY EMAIL/PHONE (VOICE MESSAGE) YES/NO** (PLEASE CIRCLE)

**CONSENT TO SMS CONTACT/REMINDERS FROM THE SURGERY YES/NO** (PLEASE CIRCLE)

**CONSENT TO SEND DE-IDENTIFIED DATA YES/NO** (PLEASE CIRCLE)

**PATIENT SIGNATURE OR PARENT/GUARDIAN:_____**

**FULL NAME:_____ TODAYS DATE:_____**