**NEW PATIENT INFORMATION FORM**

*Payment for your consultation must be made directly after your consultation,*

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| **New Patient Information** | | | | | | | | | | |
| **Date of Birth** |  | | | | | **Title:** Miss Mrs Ms Mr Mstr Dr | | | | |
| **Surname** |  | | | | | **First Name** |  | | | |
| **Middle Name** |  | | | | | **Preferred Name** | |  | | |
| **Birth Sex** | Male Female | | | **Gender Identity** | Male Female non-binary Transgender MTF/FTM Other please state: - | | | | | |
| **Pronouns** | He/Him/His She/Her/Hers They/Them/Theirs | | | | | | | | | |
| **Country of Birth** |  | | | | | **Preferred Language** |  | | | |
| **Ethnicity:** | Aboriginal & Torres Strait Islander Aboriginal Torres Strait Islander  Australian, non-indigenous Other please name: | | | | | | | | | |
| **Do you require an Interpreter?** | Auslan (National Auslan Interpreter) TIS (Translator Interpreter Service) | | | | | | | | | |
| **Australian**  **Residential Address** |  | | | | | | | | | |
| **Suburb:** | |  | | | | | | **Post Code:** |  |
| **Postal Address**  (If different to above) |  | | | | | | | | | |
| **Suburb:** |  | | | | | | | **Post Code:** |  |
| **Contact Phone** | **Mobile:** | | | | **Work:** | | | | **Home:** | |
| **Email Address** |  | | | | | | | | | |
| **Medicare Number** |  | | | | **Ref No:** | |  | | **Expiry:** |  |
| **Concession Card** | Pension Health Care Card  Seniors Health Care Card | | | | **Card No:** | | | | **Expiry:** |  |
| **DVA Card** | Gold White | | | | **Card No:** | | | | **Expiry:** |  |
| **DVA White Card** | Specific conditions: - | | | | | | | | | |
| **Occupation** |  | | | | | | | | | |

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| --- | --- | --- | --- |
| 1. **Next of Kin** | | 1. **Emergency Contact** | |
| **Name** |  | **Name** |  |
| **Relationship** |  | **Relationship** |  |
| **Phone No** |  | **Phone No** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Parent / Guardian details of children 16 years and under** | | | | | | |
| **First Name** |  | | **Surname** |  | | |
| **Date of Birth** |  | **Medicare No:** |  | | **Ref:** |  |

**I CONSENT TO THE FOLLOWING (Please tick accordingly):**

I agree to my emergency contact and/or next of kin being contacted in the case of an emergency or if we are unable to contact you for healthcare reasons.

I agree to receive SMS messages and/or emails for appointment confirmations, results follow up notifications and preventative health reminders.

I understand that the doctors at this practice will not prescribe Schedule 8 drugs, antipsychotics, benzodiazepines, or opioids to New Patients

I agree to the GP and/or Nurse at Birtinya Medical Centre accessing and uploading information to My Health Record for the provision of healthcare in accordance with national legislation.

I Understand Birtinya Medical Centre is a private billing practice and payment must be made directly after the consultation

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**