**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** |  |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**