PINNACLE MEDICAL CENTRE

New Patient Details and Privacy Form

Title: (Please circle) Mr Mrs Miss Ms Mast Dr

Family Name: ___________________________ **Given Name:** ________________________________

Middle Name: ___________________________ **Preferred Name:** ____________________________

Date of Birth: ___________________________ **Sex:** ☐Male ☐ Female

Do you identify as:

☐Aboriginal ☐ Torres Strait Islander ☐Both Aboriginal & Torres Strait Islander

☐Australian (non-indigenous) ☐Other (state)____

Residential Address: ____

Suburb_______________________________________ **State:** ___________ **Post Code:** ___________

Phone Contact: Home: ___________________ **Mobile:** ____________________________________

SMS reminder (to your mobile) – do you consent? ☐**Yes** ☐**No**

Medicare Card Number:

☐☐☐☐ - ☐☐☐☐☐ - ☐ Ref no. ☐ Expiry date ___/___/___

Concession/Centrelink Card Number:

☐☐☐☐☐☐☐☐☐ ☐ Expiry date __/__/__ Type: ☐ Pension ☐Healthcare

Department of Veterans' Affairs Card Number: ____

Type: ☐GOLD ☐WHITE (If White, please add condition/s) ____________________________

Emergency Contact:

Name: _______________________Contact No: _________________Relationship: ________________

Next of Kin:

Name: _______________________Contact No: _________________Relationship: ________________

How did you hear about our practice?____

Patient/Guardian Signature: ____Date: ____/____/____

*Please return this completed form to Reception with your **CURRENT MEDICARE CARD** and **CONCESSION CARDS**. Without these cards, there may be a PRACTICE FEE which MUST BE PAID at the end of your consultation.*

Updated 09/05/2019