UPPER ROSS 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 / / ❑ **Male** ❑ **Female**

Country of Birth (ethnicity) **AUSTRALIAN** **OTHER (state)**

If you were born in Australia

Do you identify as… (please tick 'Yes' or 'No')

Aboriginal? ❑ Yes ❑ No

Torres Strait Islander? ❑ Yes ❑ No

Address **State** **Post code**

Pho ne Home: ( ) Work ( ) Mobile

SMSappointment reminders (to your mobile) – do you consent? ❑ Yes ❑ No

Medicare Card Number

□□□□ - □□□□□ - □**Ref no.** □**Expiry date** /20

❑**Pension / Health care card No.** Expiry Date: **Type:**❑Pension ❑ADF ❑Healthcare

□□□□□□□□□□

❑**DVA No.** ❑**GOLD** ❑**WHITE**If white - add condition/s below

NEXT OF KIN

Name **Address**

Relations hip **Phone** **(H)(W)(M)** (please circle)

How did you hear about our practice?

Do you have any family members who attend here? ❑ Yes - who?❑ No

Patient signature/Guardian Signature **Date / /**

Please return completed form to Reception with your CURRENT MEDICARE CARD and CONCESSION CARDS if you have. Without these cards, there may be a PRACTICE FEE which must be paid at the end of consultation.