TOUKLEY FAMILY PRACTICE

New Patient Details Form

Please assist us by completing the following information:

Surname:		**Select:** Mr Mrs Ms Miss Master
First Name:	**(Known as):**	**Date of Birth:** / /
Street address:		
Suburb:		**Post Code:**
Phone No Home:	**Work:**	**Mobile:**
Email Address:		

Medicare Number:											**Ref No.**	**Expiry Date:**
DVA Number:											**Expiry Date:**	
Pension Number:											**Expiry Date:**	
Health Care Card Number:											**Expiry Date:**	
Commonwealth seniors card											**Expiry Date:**	

Ethnicity? (Country of Origin)			
Are you of Torres Strait Islander Origin?		**Yes: [ ]**	**No: [ ]**
Are you of Aboriginal Origin?		**Yes: [ ]**	**No: [ ]**
Next of kin:	**First Name** **Surname**	**Relationship:**	**Phone:**
Emergency contact:	**First Name** **Surname**	**Relationship:**	**Phone:**

Do you have an allergy? Yes/ No If Yes, please provide details:

Do you need assistance in registering for your "My Health Record"? **Y / N**
Would you like to receive SMS reminders for appointments and check-ups? **Y / N**
Would you like to be involved in recalls for preventative health? **Y / N**
Would you like to receive information regarding new services promoting preventative healthcare? **Y / N**
I consent to share my health information with other health professionals. **Y / N**

How did you hear about us? [ ] Radio [ ] Flyer [ ] Yellow Pages [ ] Newspaper [ ] Web Page [ ] Word of Mouth

Privacy:
All patient information is considered private and confidential and is only accessible to authorised staff members.

Due to the Privacy Act we need to know if at any time someone else may be collecting personal information for yourself ie picking up prescriptions or referrals. If this is something you may need to do, please ask reception for a form to complete so that we have this information readily available when needed.

Signed…….... **Date:** / /

For office use only: [ ] Driver's Licence/Proof of ID, scanned to patient file