NEW PATIENT DETAILS FORM

Date: ..... / ..... / .....

Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr Date of Birth: .....

Last Name: ..... First Name: .....

Street Address: .....

Suburb: ..... Postcode: .....

Home Phone No:..... Work Phone No:.....

Mobile No: .....

Email: .....

Marital Status: ..... Occupation:.....

Medicare No: ..... Expiry Date:..... Ref: .....

DVA Card No: ..... Expiry Date:..... ☐Gold ☐White

Pension Card No: ..... Expiry Date:.....

Health Care Card No: ..... Expiry Date: .....

Name of Next-of-Kin: ..... Phone: .....

Relationship to you: .....

Name of Emergency Contact: ..... Phone: .....

How would you prefer we contact you? ☐Home Phone ☐Work Phone ☐Mobile ☐Email ☐Mail

a) May we leave a message on your phone/voicemail regarding an appointment? ☐No ☐Yes

b) May we leave a message regarding your appointment with a family member who answers the phone?

☐No ☐Yes - please state name and relationship: .....

c) May we put your name on a formal reminder system for preventive care? ☐No ☐Yes

PLEASE SIGN HERE IF YOU CONSENT TO THE ABOVE: .....

How did you hear about Doctors on Buderim? *ok to tick more than one*

☐Yellow Pages ☐Yellow Pages Online ☐Flyers ☐Newspaper - SC Daily ☐Seniors Newspaper

☐Signage ☐Google Search ☐Our Website ☐Other Website: .....

☐Other referral (please detail): .....

The following information will assist us in the planning and provision of the best possible care:

Are you of Aboriginal or Torres Strait Islander origin?

☐No ☐Yes, Aboriginal ☐Yes, Torres Strait Islander ☐Yes, Both Aboriginal and Torres Strait Islander

Are you from another cultural background? ☐No ☐Yes:.....

Is English your first language? ☐No ☐Yes

If English is NOT your first language, do you need an interpreter? ☐No ☐Yes

Do you smoke? ☐No ☐Yes - how many per day on average: .....

We value your privacy. All information about you is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988). We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

☐ I consent to the use and disclosure of my personal health information as required for my health care

Signature:..... Date: .....

Office Use Only

Dr
Staff
Scan