

New Patient Form

Welcome. Please take care in providing your details accurately.



Title: _____ Given Names: _____ Surname: _____

Date of birth: ___/___/___ Gender: (Please tick) Male Female Intersex/Other

Known as: _____

Medicare No. _____ Ref No. _____ Exp. Date _____ Private Health Fund _____

Concession or Veterans Affairs # _____ Exp. Date _____

Home Address: _____ *include apartment no.

Phone: _____ Mobile: _____

Email: _____

Marital Status Single Married De facto Separated Divorced Widowed

Any known allergies: _____ Adverse Reaction _____

We collect this information in case of emergency:

Next of kin:

Name: _____ Relationship to you: _____

Phone: _____ Mobile: _____

Emergency contact (if different to above):

Name: _____ Relationship to you: _____

Phone: _____ Mobile: _____

Occupation _____ Employer _____

HEALTH INITIATIVES

Australia is a genuinely multicultural society. To assist us in providing appropriate health initiatives, please answer the following:

Are you Aboriginal or Torres Strait Islander?

Yes- Aboriginal Yes- Torres Strait Islander Yes – Aboriginal and Torres Strait Islander No

Country of Birth _____ Year of arrival in Australia _____

Preferred Language _____ Interpreter required Yes No

Privacy Statement

MC Medical and Dental is committed to maintaining the confidentiality of your personal health information. Your medical record is a confidential document. This practice has a policy to maintain security of personal health information at all times, and to ensure that this information is only available to authorized members of staff. We have a more comprehensive Privacy Policy that you are welcome to read upon request.

Payment Policy

Full payment is required after your consultation via Cash or EFTPOS/credit card, if you have any questions in regard to your payment please speak to Reception staff. Please note that our doctors do not see TAC or Workcover patients

Reminders

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail, telephone or SMS for procedures such as vaccinations, pap smears and other health reviews that you may be due for.

I wish to be included in your clinical reminder system:

Please tick one: Yes No

Transfer of Health Information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your further health care needs. You may wish to have a copy or summary of your health records transferred to this practice. Please Ask the receptionist for information about how this can take place.

Follow-ups and referrals

We ask patients to book follow-up appointments to review any test results before being discharged from care. Please note that results can only be given to you by your GP. Please refrain from asking for them by telephone or email. Please advise the practice if you are unable to proceed with any recommendations (referral, management plans, etc) so that other arrangements can be made for you.

Signature of patient or guardian _____ Date ____ / ____ / ____

If you are completing this form for your child (under 16), please ask the receptionist for the additional payee form.