NEW PATIENT REGISTRATION FORM

Personal History: **Date:**

Title	Mr/Mrs/Ms/Dr/Other ……		
First Name			
Surname			
Date of Birth	/ /		
Address			
Postcode			
Phone (Home)			
Phone (Work)			
Mobile			
Email address			
Gender	Male □ Female □	Marital Status:	Occupation:

Person to contact in an emergency/Next of Kin

Name	
Relationship	
Address	
Phone (Home) Mobile	

For **medical reasons** please state your **ethnicity**:

Please circle below:

Aboriginal Torres Strait Islander Australian Other ……

What is your primary language: English □ Other ……

Billing Information

Medicare number		Expiry date:	Ref no.
DVA Gold/White number		Expiry date:	
Pension Card number		Expiry date:	
Health Care card number	Expiry date:		

Consent

We require your consent to collect personal information about you and to use the information you provide in the following ways:

- Sending health record information to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests.
- Sharing your health information with other doctors in this practice, locums etc attached to the practice for the purpose of patient care.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I consent to the above:

Signature: …… Date: ……

Preferred Communication

What is your preferred way to be contacted? Phone □ Mail □ Email □

Would you like to receive our newsletter electronically? Yes □ No □

How did you hear about Ocean Family Medicine?

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