BRASSALL CLINIC – New Patient Details Form

We are committed to providing out patients with the best care, to do this it is essential that your medical records are up to date and accurate. Please complete this form along with your medical history and hand back to reception when you have competed.

PERSONAL DETAILS					
Title	☐ Mr	☐ Mrs	☐ Miss	☐ Ms	☐ Mstr
Surname		**First & Middle Name**			
Known As		**Sex**	☐ Male	☐ Female	
Date of Birth	/ /	**Country of Birth**			
Do you identify as one of the following?	☐ Aboriginal	☐ Torres Strait Is	☐ Do not wish to answer		

MEDICARE/BILLING DETAILS					
Medicare #		**Ref #** (next to name)		**Expiry**	
Concession Card #				**Expiry**	
Concession Card Type	☐ Pension	☐ Health Care Card	☐ Commonwealth Health Care Card		
Veteran Affairs	☐ Yes	☐ No	**Type**	☐ Gold	☐ White
If White Card, Disabilities Please List					
Private Health Cover	☐ Yes	☐ No	**Fund Name:**		
Fund Cover Type	☐ Basic Hospital	☐ Intermediate	☐ Top Hospital	☐ Extras Only	
Please nominate payer of accounts	☐ Yourself	☐ Mother	☐ Father	☐ Other (please specify)	

CONTACT INFORMATION			
Street Address			
Postal Address			
Contact Numbers	**(H)**	**(M)**	**(W)**
Email Address			

OTHER INFORMATION					
Occupation					
Marital Status	☐ Married	☐ Single	☐ Widow	☐ Defacto	☐ Other
Will you require an interpreter service for telephone calls/consultations?				☐ Yes	☐ No

EMERGENCY CONTACT (All patients under the age of 16 years must be completed by parent/guardian/carer)				
Full Name		**Date of Birth**	/ /	
Address				
Contact Numbers	**(H)**	**(M)**	**(W)**	
Relationship				

REMINDER SYSTEMS			
Our practice provides patients with preventive care and early case detection reminders. Examples of this include immunisations, annual health checks, skin checks, pap smears etc.			
Would you like to have relevant health reminders sent to you?		☐ Yes	☐ No
If we need to contact you what is your preferred method of contact?	☐ Phone	☐ Mail	☐ Email

PRIVACY POLICY			
The privacy policy of this practice informs you that in the interests of your health care we need your consent to collect health and personal information from you. This information will be used by this practice for your health treatment and for administrative purposes, and as such it may be necessary for us to exchange or disclose this information with others involved in your broader health care. If you have any concerns regarding our handling of your information please discuss this with your doctor or the receptionist.			
I have read and understand the above information		☐ Yes	☐ No
Signature of patient		**Date**	