Carnegie Malvern Medical Centre

New Patient Registration Form

(Please tick relevant boxes & use block letters)

Mr/Mrs/Ms/Miss/Master *Surname*: _____ *Given Name*: _____

Preferred Name: _____

Date of Birth: ____/_____/_____

Birth Sex: Male ☐ Female ☐ *Gender Identity:* Male ☐ Female ☐

Are you *Aboriginal* ☐, *Torres Strait Islander* ☐, *both* ☐, or *neither* ☐?

Country of Birth: _____ *Ethnicity:* _____

Do you speak English? *Yes* ☐ *No* ☐ If no, what is your preferred language? _____

Are you hearing impaired? *Yes* ☐ *No* ☐ Do you require an interpreter? *Yes* ☐ *No* ☐

Do you have a Medicare card? *Yes* ☐ *No* ☐

If yes, _____ *Ref. Number:* ____ *Expiry Date:*_____/_____

Do you have a concession card? If yes, what type?

☐ *Seniors Health Card* ☐ *Pensioner Concession Card* ☐ *Health Care Card*

What is the number? _____ Expiry? _____

Do you have a Veteran's Affairs Card? *Yes* ☐ *No* ☐ If yes, the number is _____

Address: _____

Surburb/Town: _____ *State:* _____ *Postcode:* _____

Contact Number: _____

Alternative Contact Number (If applicable): _____

Email address: _____

Next of Kin

First Name: _____ *Surname:* _____

Phone Number: _____ *Relationship to Patient:* _____

Emergency Contact

First Name: _____ *Surname:* _____

Phone Number: _____ *Relationship to Patient:* _____

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New Patient Consent Form

I have read the Privacy information provided and I understand the reasons why my information must be collected and agree to that collection. ☐

I understand that I am not obliged to provide any information requested of me, however, failure to do so may compromise the quality of health care and treatment given to me. ☐

I have read the information provided on making my record available to My Health Record and agree to the uploading of my information. ☐

I have read the billing policy information provided to me and understand and agree to the cost of my consultation. ☐

I consent to:

- The sharing of my medical information with other authorised health professionals. ☐
- Being part of the Recall/ reminder system for appointments and clinical follow up. ☐
- SMS/Text messages being sent to my mobile phone. ☐

I agree to a third party (e.g. medical students) being present during my consultation. I am aware that I can revoke that consent at the time of a particular consultation if I wish to do so. ☐

Patient's Name: _____

*Patient's Signature:*_____ *Date*: ____/____/_____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____