**New Patient Information Form**

We are committed to providing our patients with the best care.

To do this, it is essential that your personal information is up to date and accurate.

Knightsbridge Medical Centre

**SURNAME \* MISS \* MS \* MRS \* MR \* DR**

**FIRST NAME**

**DATE OF BIRTH**

**MEDICARE NUMBER Ref No. Expiry Date**

**\*DVA Gold / White (Please Circle) Expiry Date**

**\* CONCESSION CARD eg: Pension/HCC/Seniors HCC Ref No. Expiry Date**

**RESIDENTIAL ADDRESS**

**POSTAL ADDRESS**

**MOBILE PHONE HOME PHONE**

**EMAIL ADDRESS**

**MARITAL STATUS**

**OCCUPATION**

**COUNTRY OF BIRTH ETHNIC**

**BACKGROUND**

*DETAILS OF YOUR* ***NEXT OF KIN*** *DETAILS OF YOUR* ***EMERGENCY CONTAC T***

|  |  |
| --- | --- |
| \* NAME **D.O.B** | \* NAME **D.O.B** |
| \* RELATIONSHIP TO PATIENT | \* RELATIONSHIP TO PATIENT |
| \* ADDRESS | \* ADDRESS |
| \* PHONE NUMBER  (H) (M) | \* PHONE NUMBER  (H) (M) |

**DO YOU IDENTIFY AS BEING** Aboriginal ? Yes No

Torres Strait Islander ? Yes No

Other Cultural Group (Please state) ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT**

I give consent and understand the reasons why my information must be collected, and the purposes for which my information may be used or disclosed. I understand that if my information is to be used for any purpose other than that set out, my further consent will be obtained. I also give permission for my personal information to be collected, used and disclosed as described above, including contact via SMS to my mobile phone number. I understand only my relevant personal information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

# This information may be shared with other providers involved your care. Our Privacy Policy is available at reception

Signature: Date:

If not patient signing - your name (please print)

Your relationship to patient (e.g. Mother, Father, guardian)

How did you hear about us (Please circle)

Internet Letterbox Drop Word of mouth Advertising Current patient Photo ID checked by staff