

Please assist us by completing the following information:

<b>Surname</b>		<b>Select</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Master	
<b>First Name</b>		<b>(Known as)</b>	<b>D.O.B.</b>
<b>Street Address</b>		<b>Suburb</b>	<b>Post Code</b>
<b>Phone (H)</b>	<b>Work</b>	<b>Mobile</b>	
<b>Email Address</b>			

<b>Medicare Number</b> * Patient Ref No. (Next to your name on the card)											*	Expiry Date	
<b>DVA Number</b>												Expiry Date	
<b>Pension Number</b>												Expiry Date	
<b>Health Care Card Number</b>												Expiry Date	
<b>Commonwealth Seniors Card</b>												Expiry Date	

What is your Ethnicity (Country of Origin)?			
Are you of Torres Strait Islander Origin?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>
Are you of Aboriginal Origin?	Yes <input type="checkbox"/>	No	<input type="checkbox"/>

<b>Next of Kin</b>	First Name	Surname	Relationship	Phone
Emergency Contact	First Name	Surname	Relationship	Phone
Do you have an allergy?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details			

Would you like to receive SMS reminders for appointments and check-ups?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would you like to be involved in recalls for preventative health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Would you like to receive information regarding new services promoting preventative healthcare?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>I consent to share my health information with other health professionals</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

<b>How did you hear about us?</b>	Yellow Pages <input type="checkbox"/>	Social media <input type="checkbox"/>	Web/Internet <input type="checkbox"/>	Word of Mouth <input type="checkbox"/>
	Flyer <input type="checkbox"/>	Advertising <input type="checkbox"/>	<b>Please advise which one</b>	

**Privacy**  
All patient information is considered private and confidential and is only accessible to authorised staff members.  
Due to the Privacy Act we need to know if at any time someone else may be collecting personal information for yourself ie; picking up prescriptions or referrals. If this is something you may need to do, please ask reception for a form to complete so that we have this information readily available when needed.

<b>Signed</b>	<b>Date</b>
For office use only: [ <input type="checkbox"/> ] Driver's Licence/Proof of ID, scanned to patient file	