Patient Information Form Date: / /

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:

Are you of Aboriginal Origin	YES	NO
Torres Strait Islander Origin	YES	NO
Country of Birth (Cultural Background):		
Is this Visit ☐ Standard Consult ☐ Workers Compensation		

Regular Practitioner			
Title (Please Circle)	Mr Mrs MS Miss		
First Name			
Surname			
Date of Birth			
Street Address			
Suburb and Postcode			
Home Phone			
Work Phone			
Mobile Phone			
Medicare Number & Ref		Expiry Date:	Ref No:
Dept. Of Veteran Affairs DVA Gold / White(specific) (Please Circle)		Expiry Date:	
Pension Number		Expiry Date:	
Health Care Card Number		Expiry Date	
Next of Kin	Name	Relation	Phone #
Emergency Contact	Name	Relation	Phone #

Reminder Systems:

Our practice provides our patients with preventative care and early case detection reminders e.g Immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

☐ Yes – Mail ☐ Yes – Email at this address ..... ☐ No

☐ Yes – SMS to this phone number ..... ☐ No

If we need to contact you what is your preferred method of contact:

☐ Home Phone ☐ Mobile Phone ☐ Mail_____

For Office Use Only Staff Initials: _____