Raworth Medical

New Patient Form

Title:______ **Given names:** ____________________________________**Surname**:__________________________________

Date of Birth: _____/_____/______ ☐Male ☐Female

Medicare no: ____ Patient Number:_________ Expiry: ________________

Private Health Insurance: ___________________________ Membership number: _____________________________________

Veteran Affairs card: __________________________________Gold card/ White card/ Other *(please circle)* Expiry______________

Pension/ Health Care card/ other *(please circle)*: ____________________________________ Expiry:________________

Are you of Aboriginal or Torres Strait Islander Origin?

☐No ☐Aboriginal ☐Torres Strait Islander ☐Aboriginal and Torres Strait Islander

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – Do you identify as someone from an ethnic or cultural background? Yes – Please elaborate ____

Address: **Postal Address:** ***(if different from home address)***

____

Phone: H) __________________________ M) _________________________________ W)____________________________

Email: ____

Occupation: ____ Where: ____

Next of Kin

Name: ____________________________________ Relationship to you:_______________________ Ph:______________________

Emergency Contact: ***(if different from above)***

Name: ____________________________________ Relationship to you:________________________Ph:_____________________

List allergies and/intolerances to medication:

ATTENTION: Please note that any new patients attending this Surgery requesting **ENDONE, OXYCONTIN, DUROGESIC/FENTANYL PATCHES, MS CONTIN, VALIUM or ALPRAZOLAM** **WILL NOT** be accommodated.

Privacy Agreement and Patient Consent:

-I hereby acknowledge that Raworth Medical complies with the privacy Act (1988) and as part of their privacy policy Raworth Medical is committed to protecting the privacy and personal information of all patients .Raworth Medical undertakes research, professional development and quality assurance/improvement activities to improve patient care. All parties accessing personal health information for this purpose have signed confidentiality agreements. I consent for my health records being reviewed as part of quality improvement activities YES/NO

- I agree to be part of a recall register (including State and National registers), to be advised of follow up visits, medical updates, and health information, and the release of my information to my prospective employer, their insurer (in the case of a work related consultation) YES/NO

-I consent to receive SMS appointment reminders. YES/NO

- During the course of providing Medical Services, we may collect further personal information. Information may also be collected via a Shared Health Summary or Event Summary through My Health Record. YES/NO

Signature of Patient or Guardian:____ **Date:** ______/_______/________

Office use only – *please tick forms of identification provided below:*

O Driver's Licence/ ID card

O Medicare card

O Pension / Healthcare card

O Private Health insurance card

(Please note – please take a copy of cards provided)