REEDY CREEK MEDICAL ACUPUNCTURE CENTRE

NEW PATIENT DETAIL FORM

Date: ..../......./.......

OFFICE USE

☐ Mr ☐Mrs ☐ Ms ☐ Miss☐ Other: ....

Will this be your regular Surgery Yes ☐ No ☐

Your Primary GP...

Ref Number on Card #

FAMILY NAME:		MEDICARE CARD NUMBER		EXP DATE	
GIVEN NAME		PENSION CARD NUMBER:		EXP DATE	
DATE OF BIRTH:		HEALTHCARE CARD NUMBER		EXP DATE	
ADDRESS:		DVA/WHITE CARD NUMBER		EXP DATE	
SUBURB & POST CODE		PRIVATE HEALTH		EXP DATE	

HOME/MOBILE PHONE:		WORK PHONE:	
EMAIL		OCCUPATION	
NEXT OF KIN &(RELATIONSHIP)		NEXT OF KIN CONTACT NUMBER	
EMERGENCY CONTACT		EMERGENCY CONTACT NUMBER	

1. If we need to contact you what is your preferred method of contact? ☐ Phone ☐ Mail ☐ Email ☐ SMS
2. Can we leave a message regarding your appointment on your answerphone/voicemail? ☐ Yes ☐ No
3. Can we leave a message regarding your appointment with another member of your family? ☐ Yes ☐ No

   If *yes* please state who: ....

   Signed: ....**Date:**...

Are you of Aboriginal or Torres Strait Islander origin: ☐ No ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal ☐ Both Aboriginal & Torres Strait Islander

4. Are you from another cultural/ Ethnicity background: ....
5. Is English your first language? ☐ Yes ☐ No If *no,* do you require an Interpreter? ☐ Yes ☐ No
6. How did you hear about us? ☐ White pages ☐Yellow Pages ☐Local Directory ☐Signage ☐ Google

   ☐Referral: .... ☐Other: ....

We value your privacy and are committed to protecting your privacy. All information about you at this practice is kept in the strictest confidence and we operate in accordance with the Privacy Act *(1988)*.

☐ I consent to the disclosure/use of my personal health information by this practice to other health providers directly or indirectly involved in my personal health care or medical treatment

I understand and consent to above. Signature: **Date:**

SCANNED

Date: ..../......./.......