Woonona Medical Practice

New Patient Information Form/Details Update Form

Title ....
(last name as on Medicare card) (given name/s as on Medicare card)

Date of birth: ...../...../..... Preferred name: ..... Pronouns:.....

Sex: Male / Female / Other (please circle) Gender: Male / Female / Other (please circle)

Street address: .....

Postal address (if different): .....

Home phone: ..... Mobile: ..... Work: .....

Email address: .....

Is Woonona Medical Practice your usual practice? Yes/No Usual doctor: .....

Occupation: .....

Do you need an interpreter? □ Yes □ No
If **YES** to an interpreter, please indicate preferred language .....

Medicare number: ..... Ref #: ..... Expiry: ...../.....

Pension/Healthcare/Commonwealth Seniors Card number: ..... Expiry: ...../...../.....

Department of Veteran's Affairs number: ..... Colour: .....

We will send your claim to Medicare on your behalf. Please speak to reception if you **do not** want your claim sent through.

Cultural Background: (Please tick)
□ Australian, nonindigenous
□ Aboriginal but not Torres Strait Islander
□ Torres Strait Islander but not Aboriginal
□ Both Aboriginal and Torres Strait Islander
□ Other, please specify: .....
□ Prefer not to say

If **YES** to Aboriginal or Torres Strait Islander, are you registered for the 'Closing the Gap' Program? □Yes □ No

Next of Kin - Name: .....

Phone number: ..... Relationship to you: .....

Emergency Contact - Name: .....

Phone number: ..... Relationship to you: .....

PLEASE CONTINUE TO THE NEXT PAGE

Australian Defence Force Service: (Please tick)
□ Never served
□ Current Australian Defence Force – Permanent Member
□ Current Australian Defence Force - Reserves
□ Past Australian Defence Force – Permanent or Reserves

Cancellation Policy:
We ask that if you cannot make your scheduled appointment you contact us as early as possible. This ensures that other patients do not miss out on available appointments. Failure to give more than 1 hours' notice may incur a cancellation fee.

Reminder Systems:
Our practice uses a recall system for vaccinations, pap smears, health assessments/health checks and other follow up appointments. We strongly suggest that you participate in this service as these recalls are important to your health.

Would you like to be contacted via **SMS**, email and post for: **appointment reminders**, recall and other test reminders or medical services we offer?

Yes / No
(Please Circle)

Please sign below to acknowledge you have read and understood our cancellation policy and information regarding our reminder and recall systems.

Name: ..... Signature: ..... Date: ...../...../.....

[OPTIONAL] I authorise the following person to take messages regarding making or changing an appointment and to request and collect scripts/referrals on my behalf.

Name: .....

Relationship: .....

Ph: .....

Patient signature to authorise the above: .....

For new patients - how did you hear about us? .....

PLEASE CONTINUE TO THE NEXT PAGE