fountainstreet
GENERAL PRACTICE

New Patient Details

Your NAME should be written as on your Medicare card

TITLE	FIRST NAME	MIDDLE NAME	SURNAME
PREFERRED NAME		**DATE OF BIRTH**	**SEX** M ◯ F ◯ Other ◯

Address _____ Home _____

Suburb_____ Postcode _____ Work _____

Email _____

Mobile_____ Occupation _____

I consent to contact via SMS reminders ☐

MEDICARE NUMBER

										LINE NO		EXPIRY DATE	

HEAD OF FAMILY (Please fill in if patient is a child under 16 years)

Name _____ Date of Birth _____

HEAD OF FAMILY MEDICARE NUMBER

										LINE NO		EXPIRY DATE	

PENSION / CONCESSION HEALTH CARD No. _____ Expiry Date _____

VETERANS CARD No _____Expiry Date _____ RECORD No. _____

DVA GOLD ☐ DVA WHITE ☐ (please tick)

NEXT OF KIN

1. Name _____ Relationship _____

   Contact phone no. _____ Is this a patient here? Yes ☐ No ☐

Please tick if you wish to record this person as an In Case of Emergency ☐

EMERGENCY CONTACT PERSON

2. Name _____ Relationship _____

   Contact phone no. _____ Are they a patient here? Yes ☐ No ☐

ETHNIC / CULTURAL BACKGROUND	**Do you identify as someone from a culturally and/or linguistically diverse background?**
ABORIGINAL ☐	NO ☐
TORRES STRAIT ISLANDER ☐	YES ☐
AUSTRALIAN (NON INDIGENOUS) ☐	If yes, please elaborate _____
OTHER NATIONALITY …… →	

PTO →

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Patient consent for use of personal health information

a) Within the practice

I acknowledge my medical records and personal health information will be shared between Drs of this practice. I understand all Drs and staff of this practice are covered by confidentiality agreements and if I don't want any part of my medical or personal information disclosed to other Drs or staff of this practice, I need to inform my usual Dr.

YES ☐ **NO** ☐

b) Outside the practice

Occasionally this practice may participate in medical research projects with outside organisations. We stress all information shared is depersonalised and names of patients are NOT given.

Do you wish to participate?

YES ☐ **NO** ☐

c) For dependants

As guardian/parent of _____ I authorise their health information to be used in the above mentioned manner.

YES ☐ **NO** ☐

Reminder System

Our practice provides our patients with preventative care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears. This practice will from time to time send reminders for various health checks.

Do you wish to participate?

YES ☐ **NO** ☐

Cancellation Fee

We do understand the need to change or cancel an appointment at Fountain Street General Practice, but in order to minimise the disruption to Drs and other patients, we ask that you please give us two(2) hours notice at a minimum. If this notice period is not observed then your Dr may choose to charge you a $30.00 cancellation fee.

Your signature

Patient/Parent/Guardian _____Date _____