

## FARRELL STREET FAMILY PRACTICE

## New Patient information sheet

How did you find out about the surgery? Yellow/White Pages, Family/Friends, Pharmacy, Employer, Google, Facebook Please Circle: Mr/ Mrs/ Ms/ Mst/ Miss / Dr Middle Name: \_\_\_\_\_Family Name: \_\_\_\_ Given/First Name: \_\_\_\_ D.O.B \_\_\_\_\_ (pref name) Residential Address: \_\_\_\_\_ State: \_\_\_\_\_ Post Code:\_\_\_\_\_ Postal Address (if different to your Residential Address): \_\_\_\_\_\_ \_\_\_\_\_ State: \_\_\_\_\_ Post Code:\_\_\_\_\_ Do you consent to SMS/Email reminders being sent to your mobile phone number/email address Occupation: Reference Number: \_\_\_\_\_ Exp date: \_\_\_\_\_ Medicare Number: Pension/HCC Number: \_\_\_\_\_ Exp date: \_\_\_\_\_ Vet Affairs Number: \_\_\_\_\_ Name of Health Fund: \_\_\_\_\_ Level: \_\_\_\_ Yes No Private Health Insurance: Next of kin name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone: Address: Emergency Contact Name (if different to NOK): \_\_\_\_\_\_Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_ Address: \_\_\_\_\_ Do you identify with another Cultural Background other than Australian? Yes No If so, please nominate your preferred Cultural Background Are you of Aboriginal or Torres Strait Islander Background? Torres Strait Islander If so please tick the following: Aboriginal Please fill out the following card details if applicable: Reference Number: Exp date: NCACCH Number:

Certain medical information is passed on to other health information organisations for resource and statistic purposes Any transfer of this information is encrypted and de-identified to protect your privacy

All medical records in this practice are protected by a Privacy Folicy Your privacy is important to us For further information please see your GP