Greythorn Doctors Clinic

NEW PATIENT REGISTRATION FORM

The Doctors and Staff at this clinic are committed to whole patient care. This includes preventative care as well as ongoing care. To enable us to carry this out, please complete the following form. This information will be treated confidentially. Thank you for your assistance.

Title: _____ Family Name: _____ Given Name: _____

Preferred Name: _____ Date of Birth: _____/_____/_____

Gender: ◯ Male ◯ Female ◯ Transgender

Address: _____

Suburb: _____ State: _____ Postcode: _____

Mobile Ph: _____ Home Ph: _____ Work Ph: _____

Email: _____

Occupation: _____

Language Spoken: _____ Is an interpreter required ◯ Yes ◯ No (Please Tick)

Marital Status: Single / Married / De Facto / Divorced / Separated / Widowed (Please Circle)

Are you Aboriginal or Torres Strait Islander? No or Yes (Please Circle)

If Yes: ◯ Aboriginal ◯ Torres Strait Islander (Please Tick)

If No, please mention your Ethnicity/Background: _____

Medicare Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ IRN/ID: _____ Exp: ____ / _____

Health Care Card/ Pension Card/ DVA Card: _____ Exp: ____ / ____ / _____

Private Health Insurance: Yes or No (Please Circle) If Yes: Hospital or Extras

DVA (Veteran Affairs) Gold/White: _____Exp: ____ /____ /____

Emergency Contact Details:

Next of Kin: _____ Gender: _____ Relationship: _____Phone: _____

☐ Same as Next of Kin

Emergency Contact:_____ Gender:_____Relationship:_____Phone:_____

☐ ***Are you planning to attend Greythorn Doctors Clinic for ongoing care? DO NOT TICK IF YOU ARE VISITING.***

PRIVACY

We must obtain your consent for messages to be left on your telephone or mobile answering or message bank regarding matters involving your health. ***DO YOU AGREE? YES / NO***

We may need to communicate with you or with other health providers regarding your healthcare, electronically. ***DO YOU AGREE? 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. ***DO YOU AGREE FOR REMINDERS TO BE SENT TO YOU BY MAIL OR SMS? YES / NO***

CONSENT *I Consent to the collection, use and handling of my information by the practice for the purposes set out above. For further information, please refer to our collection and use statement displayed at reception or ask for a copy of our Privacy Policy.*

Signature: _____ Date: _____