Waterhall Medical Centre

New Patient Form

TITLE: Mr Mrs Miss Ms Mst Other (please specify): _____

First Name (as shown on Medicare Card): _____

Surname (as shown on Medicare Card): _____

Date of Birth: _____ Gender: _____

Address: _____

Suburb: _____ Post Code: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____

Preferred method of contact (Circle One): Email / SMS
(NB: Recalls and reminders are sent by SMS only)

Occupation: _____

Are you of Aboriginal or Torres Strait Island Descent (Circle One): Yes / No
If so, are you registered with Closing The Gap? Yes / No

Do you require a translator? (Circle One): Yes / No

What is your cultural background? _____

Medicare No: __ __ __ __ __ __ __ __ __ __ Position no: ____ Expiry Date: _____

Healthcare/Pension Card No (Please circle): _____ Expiry Date: _____

DVA Card No: _____ Colour: _____

Private Health Fund Name: _____ Number: _____

Do you have allergies to?
Penicillin: Yes / No Pain Killers: Yes / No Iodine: Yes / No Latex: Yes / No
Other (please state): _____

Next of Kin: _____ Contact No:_____

Relationship: _____

Emergency Contact: _____ Contact No: _____

Relationship: _____

IT IS THE PATIENT'S RESPONSIBILITY TO FOLLOW UP ON RESULTS