Rosedale Medical Practice

New Patient Registration Form

All fields marked with an asterisk (*) are required. To be completed by ACCOUNT HOLDER / PARENT.

Personal Details

Title* ______ First Name* ______________________ Middle Initial ____ Last Name* ____________________________

Preferred Name _____________________________ Gender* Date of birth* (DD MM YYYY) _____/______/________

Female / Male / Other ____________________________

Medical Information

MEDICARE CARD - Do you have a Medicare Card?*

☐ Yes ☐ No

Medicare Number* ____ Reference Number*__________________

Children on Card:

First name:	Initial	Surname	Date of Birth	Medicare Ref No:

Health Initiatives

In order to assist us with health initiatives and tailor care

Do you identify as Aboriginal or Torres Strait Islander?*

☐ Yes ☐ No

What is your country of birth? __________________________

PENSION/HEALTH CARE CARD - Do you have a Pension/Health Care Card?*

☐ Yes ☐ No

Pension/Health Care Card Number __________________________________ Expiry Date _____________________

DVA CARD - Do you have a DVA card?*

☐ Yes ☐ No

DVA Number ____________________________________ (Gold / White)

Occupation ____

Street Address* ____

_________________________________Suburb*: __________________________Postcode*:_____________________

Home phone ____________________________ Mobile phone* _________________________________

Email address*: ____

Communication

Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recall and other test reminders?*

☐ No ☐ Yes

Emergency Contact Information

We collect this information in case of an emergency

NEXT OF KIN

First name* _________________________ Last name* ________________________________

Relationship* __________________________ Contact number* _________________________

EMERGENCY CONTACT

Same as Next of kin ☐

First name ______________________________ Last name ______________________________

Relationship ____________________________ Contact number ___________________________

Social Activities

Do you smoke?*

☐ No ☐ Yes

Do you drink alcohol?*

☐ No ☐ Yes

What was the main reason you decided to book at our practice?

Source -

Family ☐ Friend Recommendation ☐ Saw on Street ☐ Google ☐ Social Media (e.g. Facebook) ☐ HotDoc ☐ Referral from Other Health Professional ☐ Other (Please Specify) _______________________

Privacy and Terms

We are committed to protecting the confidentiality of your personal information and health records. In submitting this form, you;

1. acknowledge that we, and our service providers, will collect your personal and health information to enable us to provide you with our health services and any related communications (for example, to manage your appointment bookings); and
2. consent to our handling of your personal information in accordance with our Privacy Policy (you can access our Privacy Policy on our website, or by asking us for a copy).

Signature * ______________________________________ Date* ___________________________