Rose Bay Medical Practice

New Patient Details - ADULT

Your NAME should be written as on your Medicare Card

TITLE	FIRST NAME	PREFERRED NAME	SURNAME	DATE OF BIRTH	SEX		
					M	F	Intersex

ADDRESS: ______________________________ **Home:** ____________________

______________________________ **Work:** ____________________

Suburb: ____________________ **Postcode:** ______ **Mob:** ____________________

I consent to being contacted via SMS (mobile text message) for appointment/test reminders & recalls. Are you happy for us to use your mobile number for this purpose? ☐ Yes ☐ No

MEDICARE NUMBER ☐☐☐☐☐☐☐☐☐☐ **No. on card:** ☐ **Expiry Date:** ☐

PENSION/CONCESSION HEALTH CARD No:______________________ **Expiry Date:** __________

VETERANS CARD No: ____________________ **Expiry Date:** ________ **Record No:** __________

EMERGENCY CONTACT DETAILS:

1. **Name:** ____________________ **Relationship:** ____________________
   Tel: ____________________ **Is this person an existing patient: YES/NO**

2. **Name:** ____________________ **Relationship:** ____________________
   Tel: ____________________ **Is this person an existing patient: YES/NO**

NEXT OF KIN: (*if different from above*)
Name: ____________________ **Relationship:** ____________________
Tel: ____________________ **Is this person an existing patient: YES/NO**

ETHNIC/CULTURAL BACKGROUND:
- ☐ Australian/non-indigenous
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal & Torres Strait Islander
- ☐ Other (please specify) ____________

WHERE DID YOU HEAR ABOUT YOUR DOCTOR?
- ☐ Family/Friend
- ☐ Another medical professional
- ☐ Live in the area
- ☐ Internet
- ☐ Other: ____________

Your Doctors Patient Consent for use of Personal Health Information

a) **Within the practice:**
I, (your name) ______________ give permission for my medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of my medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.

b) **Outside the practice:**
Furthermore, I agree to allow my doctor to communicate relevant medical details to specialist doctors, hospital medical staff, pathology labs, and other health care providers e.g. physiotherapists, podiatrists, etc. involved in my medical care.

c) **For Dependants:**
As guardian/parent of ______________ I authorise that their health information also be used in the abovementioned manner.

Your signature – Patient/Parent/Guardian: ➡ ______________________ **Date:** __________

Name of Witness: ______________________ **Signature of Witness:** ______________

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