Warner Lakes Medical Precinct, 1185 Old North Road, Warner Qld 4500
Phone: 3448 0163

New Patient Details

Title: _____ **First Name:** _____ **Family Name:**_____ **Date of Birth:** __/__/____

Ethnicity: Do you identify as ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Australian or**

other Culture _____ **(please specify)**

Address: _____**Postcode:**_____

Home Phone:_____**Mobile:**_____ **Work:**_____

Email Address: _____

Your Occupation:_____

Medicare Number:_____**Ref number next to name on card**_____ **Expiry:**___/_____

Do you have Private Health Insurance? Yes _____ **Fund Name:**_____**NO** _____

DVA(Veteran Affairs) Gold?_____**White?**_____**Expiry**_____

Special condition_____

Pensioner ☐ **or Health Care** ☐ **Card Number:** _____ **Expiry:** _____

Next of Kin: _____ **Relationship:** _____ **Phone:** _____

In Case of Emergency (ICE) Contact Person:_____**Relationship:**_____

ICE contact phone number: Mobile:_____ **Home:**_____

How did you hear about this practice?_____

***By signing this form*, you consent to the use of your personal health information and disclosure of your personal health information to Bridgeman Family Practice and other health providers involved in your medical treatment and health care. I also accept that I need to follow-up the results of any pathology or radiology testing by making an appointment within two days of performing them. These results will not be given over the phone. The Practice will only contact me if there is an urgent need to do so. We use an SMS reminder system for appointments, by signing this form you agree to the use of electronic reminder system. As part of the preventative health service offered by this practice, we send out follow up reminders & recalls to your registered address. *If you do not consent to receive follow up reminders, recalls & SMS please advise your Doctor and they will record that on your clinical record*.**

Signature:_____Date:_____

Full Name (printed): _____