

**New Patient Registration Form**

MR ⬜ MRS ⬜ MS ⬜ MASTER ⬜ MISS ⬜ DR ⬜ OTHER

FIRST NAME SURNAME

DATE OF BIRTH OCCUPATION

ADDRESS POSTCODE

TELEPHONE DO YOU CONSENT TO SMS REMINDERS: YES ⬜ NO ⬜

EMAIL COUNTRY OF BIRTH

PREFERRED LANGUAGE: DO YOU REQUIRE INTERPRETER: YES ⬜ NO ⬜

ETHNICITY: AUSTRALIAN ⬜ or OTHER (please state)

DO YOU IDENTIFY AS ⬜ Aboriginal ⬜ Torres Strait Islander ⬜ non-Indigenous

Do you give us permission to access MY HEALTH RECORD to upload and view your medical history: YES ⬜ NO ⬜

**Medicare Number**

**Ref No. next to name:**  **Expiry: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_**

**Concession Card Number**

**Pensioner Concession Card** **Health Care Concession Card**

**Expiry: \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_**

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**DVA Card Number**

**Gold Card**  **White Card**  **Expiry: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_**

Next of kin (name)

Relationship

Telephone:

Emergency contact (name)

Relationship

Telephone:

**BY SIGNING THIS FORM;**

I consent to the use of your personal health information and disclosure of your personal health information to

Warner Lakes Family Practice and other health providers involved in your medical treatment and health care.

***I AM AWARE AND AGREE TO PAY A CANCELLATION FEE OF $50.00 FOR FAILURE TO ATTEND AN APPOINTMENT WITHOUT NOTICE AT LEAST 1 HOURS BEFORE.***

These results will not be given over the phone. The Practice will only contact me if there is an urgent need to do so. 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 please advise your doctor and they will record that on your clinical record\*.

***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 the test(s).***

SIGNATURE DATE