NEW PATIENT INFORMATION FORM

BAY MEDICAL CENTRE

We are committed to providing patients with the best care. To do this it is essential that your personal information is accurate and up to date

Male Female Dr. Mr. Mrs. Miss Ms Child (Please circle)			
SURNAME:			**DRIVERS LICENCE NO.**
GIVEN NAMES:			
DATE OF BIRTH: / /		**MARITAL STATUS:**	**COUNTRY OF BIRTH:**
RESIDENTIAL ADDRESS:			
SUBURB:		**POST CODE:**	**OCCUPATION**
HOME PHONE:	**MOBILE:**		**BUSINESS:**
MEDICARE No:		**Ref #**	**EXP DATE: ____/____/____**
PENSION: or (please circle) **HEALTHCARE CARD:**			**EXP DATE: ____/____/____**
DVA:			**EXP DATE: ____/____/____**
DO YOU IDENTIFY AS BEING: (Please circle)	Aboriginal Origin	Yes	No
	Torres Strait Islander Origin	Yes	No
	Aboriginal & Torres Strait Islander Origin	Yes	No
	Other culture (please specify)		
NEXT OF KIN:	**PHONE:**		**RELATIONSHIP TO PATIENT:**
EMERGENCY CONTACT:	**PHONE:**		**RELATIONSHIP TO PATIENT:**
DO YOU HAVE ANY ALLERGIES? If so please list allergies and severity of reaction(s).			
DO YOU HAVE A REGULAR GP ELSEWHERE?		Yes	No

The billing policy of this practice is to Bulk Bill all Pension Card Holders, Health Card Card Holders and children up to the age of 16. All others please be aware that a fee may apply to your consultation which is claimable for partial repayment from Medicare. Photo ID must be provided. Please be aware that some medications will not be supplied without photo identification. Current concession cards MUST be presented on arrival.

Work related injury or illness will attract a separate fee structure. Please see receptionist if you require an further information regarding any fees.

<u>NO RESULTS</u> ARE GIVEN OUT OVER THE PHONE. An appointment is required with your doctor.

APPOINTMENTS ARE REQUIRED FOR ALL REPEAT PRESCRIPTIONS-NO EXCEPTIONS

Pathology, Radiology and Specialist investigations will attract separate fees from those providers.

This practice uses a reminder/recall system for results and preventative care. Please indicate below if you DO NOT wish to receive reminders.

☐ **I DO NOT WISH TO RECEIVE ANY REMINDERS/RECALLS from this practice. Please put a cross in the box to indicate.**

When you register as a patient of this practice, you provide consent for our GP's and practice staff to access and use your personal information so they can provide you with the best possible healthcare. Only staff who need to see this information will have access to it. If we need to use your information for anything else, we will seek additional consent from you to do this. There are brochures available at reception outlining how and why your information may be shared.

The Doctors in this Practice endeavour to give all patients as much time as necessary. Unfortunately delays are sometimes unavoidable, particularly in times of emergency or when serious and unexpected situations arise. Priority is always given to these cases and we ask for your understanding and cooperation when this happens. You can assist us by rescheduling your appointment if you are unable to attend. If you have several or complex issues to discuss, please ask for a long appointment.

Please sign and date below to indicate you have read and acknowledge our Fees & Policies

Patient or Parent/Guardian Name (Please print).....Date:...../...../.....

Patient or Parent/Guardian Signature..... Date:...../...../.....