

 **6 Memorial Avenue, Nuriootpa SA 5355 Telephone 8562 2444 Fax 8562 3444**

 **Email: manager@nuridocs.com.au**

**Dr J. Markey, Dr G. Arthurson, Dr M. Hoopmann, Dr P.Wells,**

 **Dr P. Murugiah, Dr Q. Teo, Dr C. Chang, Dr A. Ward,**

 **Appointments can be made on line at** [**www.healthengine.com.au**](http://www.healthengine.com.au) **and download the app**

**NEW PATIENT INFORMATION FORM**

**🞏**Mr 🞏Mrs 🞏 Miss 🞏 Ms 🞏 Master 🞏 Dr

Patient Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_ /\_\_\_ /\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| ***\*\*if under 18 must provide a- parent’s details for billing purposes \*\****\*\*Parents Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ |

Patient Residential Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Postal Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone Number: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\****We ***send free sms appointment reminders*** please tick if you **don’t** wish to receive reminder 🞏

Your **CULTURAL IDENTITY**  to assist with Health Initiatives **(please specify)**

🞏 **ABORIGINAL**  🞏 **TORRES STRAIT ISLANDER** 🞏 **OTHER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE NUMBER**

🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏 **Ref #** 🞏 expiry: \_\_\_/\_\_\_/\_\_\_\_\_

**CONCESSION CARD** (**PENSION or HEALTH CARE CARD**) - **(please CIRCLE WHICH ONE)**

🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏 Expiry: \_\_\_/ \_\_\_/\_\_\_\_\_

**DVA CARD**

🞏🞏🞏🞏🞏🞏🞏🞏🞏🞏 White/gold card expiry: \_\_\_/ \_\_\_/\_\_\_\_ **P.T.O.**

**PRIVATE HEALTH INSURANCE**

**Fund Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_ **Policy Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEXT OF KIN:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone Number (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT PERSON:** (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone Number (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I GIVE PERMISSSION FOR (Name)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO COLLECT MEDICAL INFORMATION ON MY BEHALF**

Relationship to you**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR PRIVACY & MEDICAL INFORMATION**

This medical practice collects information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly access, diagnose, treat, and be proactive in your health care needs.

This means that we will use the information for administrative purposes, billing, disclosure to others involved in your health care; including specialists and other treating doctors outside the practice and disclosure to other doctors in the practice including locums to assist in your medical care.

This practice may occasionally be involved in research and quality assurance activities to improve individual and community health care and practice management. All information is de-identified.

If you wish to opt out of any research undertaken by the clinic please inform your doctor. We wish to assure you that at all time your health information are treated with utmost confidentiality.

🞏 I have read and understood the above information regarding my medical information

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/ \_\_\_\_\_\_/\_\_\_\_\_

**\*It is important that all your information is up to date and correct\***

**Please return FULLY COMPLETED FORM to our Receptionist.**

**Thank You for your co-operation.**

Knowhow / Reception Forms Updated 11/2017