NURIOOTPA
MEDICAL CENTRE

6 Memorial Avenue, Nuriootpa SA 5355
Telephone 8562 2444 Fax 8562 3444
Email: manager@nuridocs.com.au

Appointments can be made on line at 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.**

CONFIDENTIAL

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**:** ____

CONFIDENTIAL

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.