

PATIENT DETAILSTITLE ☐ 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 AN INTERPRETER

☐ Yes ☐ No

ETHNICITY

☐ Australian ☐ Other (please state) _____

DO YOU IDENTIFY AS

☐ Aboriginal ☐ Torres Strait Islander ☐ non-IndigenousDo you give us permission to access **My Health Record** to upload and view your medical history?☐ Yes ☐ No**MEDICARE, CONCESSION & DVA**

MEDICARE NUMBER

REF NO.

EXPIRY

_____/_____/_____

CONCESSION CARD TYPE

☐ Pensioner Concession Card ☐ Health Care Concession Card

CONCESSION CARD NUMBER

EXPIRY

_____/_____/_____

DVA CARD NUMBER

CARD TYPE

EXPIRY

☐ Gold Card ☐ White Card

_____/_____/_____

NEXT OF KIN & EMERGENCY CONTACT**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 2 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****We're passionate about your health.**

Part of the Qualitas Health Group.

Warner Lakes Medical Precinct
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