THE ENTRANCE MEDICAL CENTRE – NEW PATIENT DETAILS FORM

Dr K Lee Dr J Scullin Dr J Harris Dr S Balaraman Dr M Kahloon

Please provide photo identification – Drivers license or another form of photo ID

Title:_____ Surname:_____ Given names: _____

Date of birth ___/___/___ Gender (please circle): Male Female

Ethnicity (please circle) Aboriginal Torres Straight Islander (TSI) Non-Aboriginal or TSI

Home address:_____

Postal address: _____

Phone (Home): _____ Work: _____ Mobile: _____

Email address: _____

Marital status (please circle) Single Married Defacto Separated Divorced Widowed

Medicare No:_____ Ref No:_____ Expiry date: _____

Veterans Affairs No: _____ Expiry date: _____

Pension Card No: _____ Expiry date: _____

Health Care Card No: _____ Expiry date:_____

Emergency contact details:

Name: _____ Relationship to you: _____

Phone (Home): _____ Work: _____ Mobile: _____

Next of kin (If different from above)

Name: _____ Relationship to you: _____

Phone (Home): _____ Work: _____ Mobile: _____

Does this person have consent to collect your documents on your behalf (please circle) Yes No

Our practice undertakes research, professional development, and quality assurance/improvement activities to improve patient care. All people accessing personal health information for this purpose have signed a written confidentiality agreement.

I consent to my health record being reviewed as a part of the quality improvement activities in this practice.
(Please circle) Yes No

Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap smears and other health reviews.

I consent to being contacted with reminders. (Please circle) Yes No

Signature of patient or guardian _____ Date ___/ ___/ ___