PARKINSON MEDICAL HUB

NEW PATIENT FORM

PATIENT DETAILS

TITLE:_____

FAMILY NAME:_____

GIVEN NAME/S:_____

PREFERRED NAME:_____

DATE OF BIRTH:_____SEX: M / F

ETHNICITY: _____

DO YOU IDENTIFY WITH A CULTURAL GROUP? (Please Circle)

None Aboriginal Torres Strait Islander

Other:_____

COUNTRY OF ORIGIN:

_____

ADDRESS/CONTACT DETAILS

STREET ADDRESS: _____

CITY/SUBURB: _____POSTCODE:_____

POSTAL ADDRESS: _____

CITY/SUBURB: _____POSTCODE:_____

HOME PH:_____WORK PH:_____

MOBILE PHONE: _____

EMAIL: _____

IF THE PATIENT IS UNDER 18 YEARS OF AGE PLEASE NOMINATE D HEAD OF FAMILY (for Medicare purposes):

Name: _____Date of Birth: _____

Is the above named Head of Family a patient here? YES / NO

MEDICARE DETAILS

MEDICARE NUMBER:_____

REF NO (no. next to your name):_____EXP:_____

PENSION, CENTRELINK HEALTH CARE CARD OR DVA CARD DETAILS

PENSION NO:_____EXP:_____
or
HCC NO:_____EXP:_____
or
DVA CARD NO:_____EXP:_____

NEXT OF KIN

FIRST NAME:_____

SURNAME:_____

CONTACT NO:_____

RELATIONSHIP:_____

EMERGENCY CONTACT

FIRST NAME:_____

SURNAME:_____

CONTACT NO:_____

RELATIONSHIP:_____

YOUR OCCUPATION

_____

CONSENT:

Do you agree for Doctors/Staff to disclose your results and any other relevant information that may be needed by another party eg. Specialist or Hospital, for sole purpose of the quality and continuity of care? **YES / NO**

Do you agree to Doctors/Staff contacting Medicare or any other organization on your behalf for the collection of information that may be necessary for the sole purpose of quality and continuity of care? YES / NO

I acknowledge that if my doctor recommends a test, then it is my responsibility to have that test done. **YES / NO**

I acknowledge it is my responsibility to visit the doctor to review the test results. I will not assume that the results are normal if I do not hear from my doctor. **YES / NO**

I have received a copy of this practice privacy policy and understand and agree to the use of my personal information as outlined in this document. **YES / NO**

NAME:_____SIGNATURE:_____DATE:_____