

## New Patient Details Form

Please complete this form as accurately as possible. All information is confidential and managed in accordance with the Privacy Act 1988.

### 1. Patient Details

Title	First Name	Surname
Date of Birth	Gender	Preferred Name
Residential Address		

### 2. Contact Details

Mobile Phone	Home Phone	Work Phone
Email Address		
Preferred Contact Method	<input type="checkbox"/> SMS <input type="checkbox"/> Phone <input type="checkbox"/> Email	

### 3. Medicare & Concession Details

Medicare Number	Reference No.	Expiry Date
Concession / DVA Card Type	Card Number	Expiry Date

### 4. Emergency Contact

Name	Relationship	Phone Number

### 5. Cultural & Support Information

Aboriginal or Torres Strait Islander Origin	Interpreter Required	Preferred Language
<input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both	<input type="checkbox"/> Yes <input type="checkbox"/> No	

### 6. Patient Consent

I confirm that the information provided is accurate and consent to SCH Family Practice collecting and using my personal health information for the purpose of providing healthcare services.

Patient Signature	Date