**BULIMBA DOCTORS**

New Patient Registration Form

MARITAL STATUS: Single □ Married □ Defacto □ Separated □ Divorced □ Widowed □

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CULTURAL BACKGROUND – Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander Origin?

No □ Aboriginal □ Torres Strait Islander □ Aboriginal & Torres Strait Islander □

Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEXT OF KIN (NOK) DETAILS (eg. Relation or family member):

Name of NOK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOK Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOK Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT (Different to NOK if possible, eg. neighbour or close friend):

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBURB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSTCODE:\_\_\_\_\_\_\_\_

POSTAL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­SUBURB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTCODE:\_\_\_\_\_\_

HOME PH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MOBILE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consent to sms appointment reminders? Yes □ No □

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIVACY POLICY:**

In accordance with the Privacy Act (2001) all information collected in this practice is treated as ‘sensitive information’. To protect your privacy, this practice operates in accordance with the Act.

For further details on our Privacy Policy please visit our website. You can assist in maintaining the accuracy of your information by advising the practice of any changes of address, phone numbers etc.

**We are NOT a bulk billing practice. Please speak to our receptionist BEFORE your appointment if you have any queries about our practice’s billing policies.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and consent to the above privacy statement, am aware of the fee structure, and understand that payment is required on the day of consultation.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENTS UNDER 16**

This information is required for processing Medicare Claims. Medicare will not accept claims for minors.

Name of payer of account for minor: \_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_­\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Medicare No: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ Ref no: \_\_

MEDICARE CARD NO: **­**\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_Place on card\_ EXP DATE\_\_/\_\_

CONCESSION TYPE: Pensioner Concession □ Health Care Card □ Commonwealth Seniors Card □

PENSION/HHC NO: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ EXP DATE:\_ \_ /\_ \_

DVA NO: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ CARD COLOUR: Gold/White/Lilac/Orange

If your DVA card covers certain conditions, please state condition(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

Smoking status: Non-Smoker □ Smoker □ Ex Smoker □ If smoker, how many cigarettes per day? \_\_\_\_

Alcohol: Do you drink alcohol? No □ Yes □

If yes, how many days per week do you drink? \_\_\_\_ How many standard drinks per day (when drinking)? \_\_\_\_

Do you have any known allergies? (Eg. Medication, food, bees etc): No □ Yes □ (please provide details ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Bulimba Doctors is a PRIVATE BILLING PRACTICE**

Our fees may vary depending on the complexity, length & time of your appointment.

Full payment is required on the day at the time of your consultation. Bulk-Billing is available in certain exceptional circumstances; please speak to staff prior to your appointment.

TITLE: \_\_\_\_\_ FAMILY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GIVEN NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MIDDLE INITIAL: \_\_\_ PREFERRED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (dd/mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_

GENDER: Male □ Female □