NEW PATIENT REGISTRATION FORM

Please complete sections in full and sign at the bottom

** PHOTO ID TO BE SHOWN TO RECEPTION **

Patient Details			
Title:	Given Name(s):	Surname:	Preferred Name:

DOB: *DD/MM/YYYY*	Gender:	Gender Identity:
	☐ Male ☐ Female ☐ Other	☐ Transgender ☐ Non-Binary ☐ Gender Diverse ☐ Different Identity

Pronouns:	Country of Birth:	Interpreter Required?
☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs		☐ No ☐ Yes *Language:* _____

Ethnicity: *eg:Asian,African,Caucasion,NZ*	Are you of First Nations origin?	Occupation:
	☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both	

Home Address:	Postal Address – *If different from Home*
Suburb: Postcode:	Suburb: Postcode:

Mobile:	Home Phone:	Email:

Medicare / DVA / Concessions					
Do you have a Medicare card?	☐ No ☐ Yes	Are you MyMedicare Registered at another GP?	☐ No ☐ Yes ☐ Unsure		
Medicare Card Number:		Reference Number:		Expiry:	
Do you hold a DVA Card?	☐ No ☐ Yes-*Gold* ☐ Yes-*White*		DVA Number:		
If White please list all specific conditions:					
Are you a Concession Card Holder?	☐ No ☐ Yes	CRN Number:		Expiry:	

Next of Kin & Emergency Contact (*please tick the box in Emergency Contact if the same as NOK)*			
Next of Kin:		Emergency Contact:	☐ Same as NOK
Name:		Name:	
Phone:		Phone:	
Relationship:		Relationship:	

Consent & Acknowledgement – Please read before signing

SMS Communication Consent

I consent to the practice contacting me via SMS for appointment reminders, recalls, and other test reminders or medical services. ☐ No ☐ Yes

Failure to Attend / No Show policy

- I am responsible for attending my appointment, and for notfying the practice if I am unable to attend.
- An automated SMS will be sent the day before my appointment and I am responsible for replying "Yes"or"No
- If unable to attend I will give at least 2 hours' notice so other people have the chance to see the GP.
- If I fail to attend without notice, I may be charged a no show fee which is payable in full before rebooking another appointment.

Practice Fees

I acknowledge that this is a mixed billing practice and I accept responsibility for payment of all associated fees.

If Patient is under 16, Parent or Guardian details must be provided – *this person will be made Head of family for billing purposes.*			
Name:		DOB: *DD/MM/YYY*	
Relationship:		Phone:	

Date: _____

Patient or Parent / Guardian Signature

U11 1 Swordfish Avenue Taranganba Q 4703
P: 07 4939 1888 F: 07 4939 1433

20 Pattison Street Emu Park Q 4710
P: 07 4807 6510 F: 07 4910 5237