NEW PATIENT REGISTRATION FORM

MR MRS MS MISS MST (please circle)

SURNAME: ______________________ **FIRST NAME:** ______________________

Preferred Name: ______________________ **D.O.B:** ______________________

To assist with Health Initiatives - are you Aboriginal and/or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes, both - Aboriginal and Torres Strait Islander

As Australia is a genuinely multicultural society, and to tailor appropriate care, encourage understanding and Appreciation between people from different nationalities and cultures - do you identify as someone from a culturally and/or linguistic diverse background? ☐ No ☐ Yes - Please elaborate ______________________

If yes, do you require an interpreter service? ☐ No ☐ Yes

Medicare Number: ______________________ Ref: ___ (number in front of name) Expiry: ____ /_____

Dept. of Veterans' Affairs File Number: ______________________ ☐ Gold ☐ White

Concession (Pension/Health Care) Card Number: ______________________ Expiry: ____ /_____

ADDRESS: ______________________

PO Box (If applicable): ______________________

CONTACT NUMBERS:

H: ____________ W: ____________ Mob: ____________

Email (print clearly):______________________

YOUR NEXT OF KIN'S FULL NAME:

______________________ PH: ______________________

Next of Kin's relationship to you: ______________________

YOUR EMERGENCY CONTACT'S FULL NAME: Tick box if same as Next of Kin ☐

______________________ PH: ______________________

Emergency contact's relationship to you : ______________________

YOUR MARITAL STATUS: (please circle) Married DeFacto Divorced Widowed Single Separated

YOUR OCCUPATION: ______________________

COUNTRY OF BIRTH: (please tick) Australia ☐ or Other: ______________________

At Rehman Clinic, we strive to provide high quality care, appropriate to meet our client's health care requirements.

By becoming a patient of Rehman Clinic and signing this new patient form I agree and consent to the following:

- *As part of our reminder service we may SMS you appointment reminders for extended, procedural and recall appointments*
- *I consent to the use of my personal health information being shared by Rehman Clinic and other health care providers involved in my medical treatment and health care within this centre including 'My Health Record'.*
- *I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly with my personal health care or medical treatment including 'My Health Record'.*
- *I consent that my personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed.*

Patient or Parent/Guardian Signature: ______________________ **Date:** ______________