NEW PATIENT REGISTRATION FORM

Rehman Clinic

MR MRS MS MISS MST (please circle)

SURNAME: _____ FIRST NAME: _____

Preferred Name: _____ D.O.B: _____

Do you identify yourself as: □ Aboriginal □ Torres Strait Islander □ Both □ Neither

Ethnicity: _____

Medicare Number: _____ Ref: _____ (Number in front of name)

Pension: _____ Exp: _____ /_____ / _____

Health Care Card: _____ Exp: _____ /_____ / _____

Dept. of Veterans' Affairs: _____ GOLD / WHITE Card (please circle)

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 clients 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'.*

Patient/Guardian Signature: _____ **Date**: _____