

## **New Patient Registration**



PATIE	NT DETAILS:												
Title	First name	Surname					DOB			Male			
										Female	:		
										Other			
ADDRE	ESS:						TELEPHO	NE:					
RESIDEN	TIAL/POSTAL:					Home:							
		POST CODE:				Mobile:							
EMAIL:							Work:						
MEDICARE NO: REF NO:			Expiry: CONCESSION CARD PRESENT CARD TO RECEPTI							Expiry:			
			/							/			
COUNTRY OF BIRTH:			Do you require and interpreter			Do y	o you identify as:						
			YES   NO			□ Aboriginal				□ No			
Year of arrival:			Language $\Box$ T				Forres Strait islander						
Cultura	Cultural Background:			□ A				Aboriginal and Torres Strait Islander					
ALLERG	ALLERGIES:												
Are you allergic to any medication, dressings or foods? Are you anaphylactic? If so, please give details.													
PERSON	IAL STATUS:	-			OCCUPATION	ON·	-						
	e   Married/De Facto	n □ Div/	Sen □ Widov	ved	000017111	<b></b>							
NEXT O			sep = widov	vea									
Name:			Relationship Telephone/contact N				lo:						
			Home:			Mobile:							
EMERGI	ENCY CONTACT:												
Name:			Relationship Telephone/contact Home:			contact N	No: Mobile:						
RECALLS	ç.	-					_						
	consent to receiving re	ecalls and	reminders via	SMS o	r email?			П	YES		NO		
Do you	consent to receiving re	ccans and	reminaers via	31413 0	i Ciriaii.				1123		•		
CONSE	NT:												
I hereby	consent to abide by the follo	owing terms	and conditions o	f the Se	aview Family	Medica	l Centre:						
FEES &	CHARGES: I agree to pay	all fees and	charges that may	not be	overed unde	er Medic	al Benefit Sc	heme o	or unde	er manda	atory	Work	
Cover ins	surance maintained by my e nent fee that may apply.												
PRIVAC	Y PROTECTION: Seaview F	amily Medica	al Centre respects	your rig	hts under the	"Privac	y Act 1988" a	nd uph	olds yo	our rights	to pr	rivacy	
	n under Australian Privacy Pr NTATIVE HEALTH: Our prac								nders e	e.g. immı	unisa	tions,	
annual he	ealth checks, investigation re	calls, skin ch	ecks and pap sm	ears. If	you do not wi	sh to ha	ve reminder	letters	sent to	you, ple	ase ii	nform	
e-HEAL	TH: Seaview Family Medical												
	for electronically connecting g the transition to a connecte							ırely. W	/e do s	o to help	ner	ita in	
		•	·										
Patient	/ Guardian					Date					•••••	••	
Please	print name:												

