New Patient Information Form

Bournemouth Medical Centre

We are committed to providing our patients with the best care.
To do this, it is essential that your personal information is up to date and accurate.

*** FIRST NAME**		*** MISS * MS * MRS * MR * DR**	
*** SURNAME**			
*** DATE OF BIRTH**			
*** MEDICARE NUMBER**	**Ref No.**	**Expiry Date**	
***DVA Gold / White** *(Please Circle)*		**Expiry Date**	
*** CONCESSION CARD** ***eg: Pension/HCC/Seniors HCC***	**Ref No.**	**Expiry Date**	
*** RESIDENTIAL ADDRESS**			
*** POSTAL ADDRESS**			
*** HOME PHONE**	**WORK PHONE**	**MOBILE**	
EMAIL			
MARITAL STATUS			
OCCUPATION			
COUNTRY OF ORIGIN			

PLEASE CIRCLE YOUR FIRST CONTACT PERSON **Next of Kin** **Emergency Contact**

*DETAILS OF YOUR **NEXT OF KIN***	*DETAILS OF YOUR **EMERGENCY CONTAC T***
* NAME	* NAME
* RELATIONSHIP TO PATIENT	* RELATIONSHIP TO PATIENT
* ADDRESS	* ADDRESS
* PHONE NUMBER (H) (M)	* PHONE NUMBER (H) (M)

DO YOU REQUIRE AN INTERPRETER SERVICE ☐ Yes ☐ No

DO YOU IDENTIFY AS BEING: **Aboriginal origin** ☐ Yes ☐ No

Torres Strait Islander origin ☐ Yes ☐ No

Other Cultural group (*please state)* _____

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders:
e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you? ☐ Yes ☐ No

Do you consent to SMS contact/reminders from the surgery? ☐ Yes ☐ No

Patients Signature or Parent / Guardian (if child is a minor) _____

Date:_____