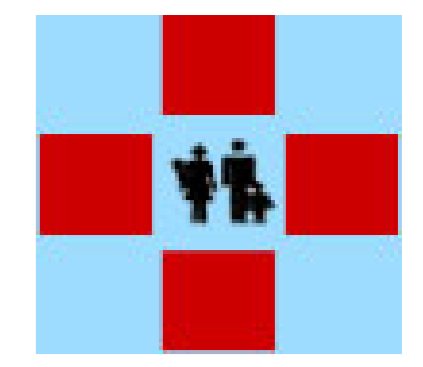


# New Patient Information Form

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 CONTACT*

* 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: \_\_\_\_\_