ELMWOOD MEDICAL CENTRE

New Patient Questionnaire

Title: Mr Mrs Ms Miss Master **(please circle)**

Surname: _____ **Given Name:** _____

Date of Birth: ____/____/___**Preferred Name:** _____**Gender:**_____

Home Address:_____

Suburb: _____ **Postcode:**_____

Home telephone: _____ **Mobile:**_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ **Reference Number:** __

Expiry date: __ __/ __ __

Pension/ HCC Number: _____ **Expiry Date**_____

DVA Gold/White Card Number: _____ **Expiry Date**_____

NEXT OF KIN / EMERGENCY CONTACT DETAILS:

Contact 1. Full Name: _____ Relationship to patient: _____

Phone Number: _____

Contact 2. Full Name: _____ Relationship to patient:_____

Phone number: _____

Do you identity with any of the following

Aboriginal	**Y / N**
Torres Straight Islander	**Y / N**
Aboriginal & Torres Straight Islander	**Y / N**
Other (please state)_____	

Would you like to registrar for E-HEALTH ?
Complete the attached form and your records can be accessed by any Doctor Australia Wide.

PLEASE ENSURE THAT YOU INFORM YOUR DOCTOR OF ANY EXISTING MEDICAL CONDITIONS, ALLERGIES, MEDICATIONS OR HEALTH PLANS YOU MAY HAVE

ELMWOOD MEDICAL CENTRE POLICIES & PATIENT AGREEMENT:

- Documentation, including forms, certificates and prescriptions (including repeats) will **NOT** be provided without an appointment with your Doctor.
- Results will **NOT** be given over the phone.
- Failure to attend or late cancellation (less than 1 hour notice) will incur a $30.00 fee ($60.00 for a double appointment).
- Second failure to attend/late cancellation will incur a $40.00 fee ($80.00 for double appointment).
- All fees owing must be paid in advance before patients can access appointments at our practice.
- Staff at the Elmwood Medical Centre are entitled to a workplace free from harassment and intimidation.

I have read and understood the Elmwood Medical Centre policies and I agree to comply with these policies. I understand that if I fail to comply with the above policies I may be asked to leave the premises and refused access to the clinic in the future.

Patient Signature: _____ Date: _____

Please note: All information collected is for the purposes of assisting our health service providers to deliver optimum health care. Patient's medical records and health information are confidential documents. It is the policy of the practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised staff.
This information will not be sold or otherwise shared with any parties who are not directly relevant to the health care of individual patients.