**New Patient Form **

Allied Health

**Personal:**

Title: ­­­­\_\_\_\_­ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle: \_ \_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B.: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Gender identity: □Male / □Female / □Other

Residential Address: \_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal: □AS ABOVE ­­or \_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_\_\_\_\_

*Do you consent to receiving SMS reminders for any future appointments:* □YES □NO

Email Address: ­­­­­­­­­­­­­­­­­ □ No email address
My GP/Doctor: \_\_\_\_ GP practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: □Australian, non-indigenous □Aboriginal □Torres Strait Islander

 □Both Aboriginal and Torres Strait Islander □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Please specify)

**Concession Cards (Please complete all applicable):**

Medicare No.: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_ IRN Ref: \_ \_\_\_\_ Expiry Date: \_\_/ /20\_\_\_\_

Pension/Health Care Concession No: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_ □Pen □HCC Expiry Date: \_\_/ /20\_\_\_\_

NDIS: □Self-managed □Plan-managed □NDIA/Agency-managed

DVA Card No: □GOLD non-TPI □GOLD TPI □ White (Condition/s:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Private Health Cover:** □Yes □No□Hospital Cover Only □Extras Cover Only □Both Hospital & ExtrasHealth Fund: \_\_\_\_\_\_\_\_\_\_\_ Membership No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next of Kin Details:**

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_

Relationship:
**Emergency Contact Details: □Same as Next of Kin**

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_

Relationship:

**Consent for the collection and use of information**

I hereby give consent for my private health information to be collected, communicated and transferred (verbally, electronically or in writing) by the Health Professionals at Branyan Clinic, to coordinate my care with other treating Doctors, Specialists, Pharmacies (PES) and Allied Health Professionals or uploaded to the My Health Record System as required. (In accordance with the Privacy Act 1988,NPP2)

**Late cancellation & Failure to attend POLICY:**

We require at least 1 business days’ notice for appointments being cancelled. Your appointment will be considered as not attended, if you are late for your appointment by 10 minutes or more. A consultation fee is payable if an appointment is cancelled without sufficient notice or is not attended. Any future appointments will not be booked until this fee is paid. Rebates cannot be claimed for non-attendance costs.

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/20\_\_\_\_\_\_**