**Patient Details:**

Title: ­­­­\_\_\_ \_­ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_ \_\_\_\_\_\_ \_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

Telephone: (H) \_\_\_\_\_ (M) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_   
*Do you consent to receiving SMS reminders for any future appointments:* ***YES*** □ ***/ NO*** □

Email Address: ­­­­­­­­­­­­­­­­­ *I Do Not have email address: please tick* □

**Medicare No:** \_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Ref: \_ Expiry Date: \_

**Concession Card No:** \_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Pen □ HCC □ Expiry Date: \_\_\_\_\_\_\_

**DVA Card** (if applicable): Gold □ White □ Card No.: \_\_\_\_\_\_\_\_\_\_\_\_\_

White Card Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Cultural Background:**

Ethnicity: Australian □ Aboriginal □ TSI□ ATSI □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please specify)

**Religious Background and Personal Preference:**

I would prefer a: Male Doctor □ Female Doctor □ Any Doctor □

Do you have any specific Religious / Personal requirements? No □ Yes □

If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Next of Kin Details:**

Next of Kin: First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Telephone No: (H) \_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_ (M) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:

**Emergency Contact Details: *or if “SAME AS ABOVE” (Please tick)*** □

Emergency Contact: First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (H) (W) (M) \_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**NOTE:** 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)

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