Cooroora
Family Health

Office Use only: Received by & Date | Checked by | Scanned by & Date | Doctor
…………………………………………………………………………………………………

New Patient Information Sheet

Title: ………….. Surname: ……………………..………………… First Name:……………………………………....

Middle Name: ……………………….……….……… Preferred Name: ………………………………………………...

Sex (please circle): **F** **M** Date of Birth: ……….. / ……….. / ……….. Country of Birth: …………..…………

☐ Not Aboriginal/Torres Strait Islander/South Sea Islander ☐ Aboriginal ☐ Torres Strait Islander

☐ Both Aboriginal & Torres Strait Islander ☐ South Sea Islander

Marital Status: ……………..……............ Occupation: ……………..……............ Religion: ……………..……............

Residential Address: ……………………………………………………………………………………………

…………………………………………………….……… City/Suburb: ………………………..…............ P/Code : …………...

Postal Address (If different from above): ……………………………………………………………………………

………………………………………………….……… City/Suburb: ……………………………........ P/Code : …………...

Home phone: …….…………………. Work phone: ………..…….………………. Mobile: ……………….……………….

Contact via: ☐ Mobile Ph ☐ Work Ph ☐ Home Ph ☐ SMS ☐ Email ☐ Letter

Email address: …………………………………………………………………………………………………

Please Hand Medicare and/or Pensioner/HCC/ DVA Cards to Receptionist When Handing This Form In

Medicare No.: ………………………..……………..….. Reference No. : …………. Expiry Date: ……………………
(All numbers above your name) (Number next to name) (Bottom right corner)

Health Care Card No.: ……………………………………………………….…………. Expiry Date: ……..………………

Pension Card No.: ………………………………………….…..…………………. Expiry Date: ………..…………….

Commonwealth Seniors Health Card.: …………………………………………….Expiry Date:………………………

Veteran Affairs No.: ………………………..…………………………….……………… Expiry Date: ……………..……….

PBS Safety Net No: …………………………………………………………………………………………………

Health Ins. Fund: …………………………………….……… Health Ins. No.: ………………………………………

NEXT OF KIN:

Name: ………………………………………………..…………………Relationship: …………………………………...

Address: ………

Home phone: …….…………………. Work phone: ………..…….………………. Mobile: ……………….……………….

EMERGENCY CONTACT:

Name: ………………………………………………..…………………Relationship: …………………………………..

Address: ………

Home phone: …….…………………. Work phone: ………..…….………………. Mobile: ……………….……………….

☐ **YES** ☐ **NO** **If we need to contact you for any reason and are unable to do so, do you give permission for us to identify ourselves, state that we are calling from Cooroora Family Health and leave a message?**

☐ **YES** ☐ **NO** **DO YOU AGREE TO RECEIVING REMINDERS VIA SMS**

Signed: ……………………………………………………. Date: ………./………… /

WE ARE A BUSY BULK BILLING PRACTICE, IF YOU CANNOT ATTEND YOUR APPOINTMENT, PLEASE NOTIFY US. IF YOU FAIL TO NOTIFY US 2 CONSECUTIVE TIMES, THEN YOU WILL INCUR A $40 CHARGE BEFORE ANOTHER APPOINTMENT WILL BE MADE. ………….
Thank you for your cooperation.