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| **New/Existing Patient Details Form***Welcome to Prahran East Medical Centre. Please take a moment to complete the details we require to create your record with us.****Important! If you think you may have previously been at this practice (under another name or in the past) please inform a team member prior to completing this form so that duplicate medical files are not created for you.*** | 400 High Street, Prahran EastPh: 9510 8888Fax: 9510 2666www.prahraneastmc.com.au |

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| **Personal Details** |
| **Title**: Dr Prof Mr Mrs Miss Ms Master other **First Name**:  **Middle Name**:  **Surname:** |
| *Is the name you provided exactly as it appears on your Medicare card? Yes No (please circle) If not, we need to ensure this matches otherwise your claim may not be able to be processed -* ***please amend your name if necessary.*** |
| **Preferred name if different to given name.** *I like to be called:* |
| **Date of Birth**: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Gender** : F - M - Intersex/other - Not stated ( please circle) |
| **Cultural Background:** Non-Indigenous Aboriginal Aboriginal and Torres Strait Islander Torres Strait Islander Not stated  **Other**: *(please state)*  |
| **Contact Details** |
| **Street address: Suburb:** **State: Postcode:** |
| **Phone (home): Mobile: Work:** |
| **Email:** |
| **Identification Details** |
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Medicare Number:  |

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Ref no:This is the number next to your name on the card |  Expiry Date: |
| HCC/Pension Number: (if applicable) Expiry Date: |
| DVA Number : (if applicable) Expiry Date: |
| If we refer you to another practitioner about an ongoing condition, do you give us permission to update them on your overall progress periodically (we have standard procedures allowing this communication)? **Y/ N**Are there any custody or other legal issues involving your child that we should be aware of? |

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| **Notice regarding Email and SMS:** *Our practice uses email & SMS for health or appointment reminders. Please tick if you do NOT wish to be contacted in this way. [ ]****Note we do not provide results, consultation notes or any other medical correspondence via this method.*** |
| **If you require the services of a translator please specify details here :** |
| **Marital status: Occupation:** |
| **Country of Birth :** |
| **Emergency contact person** |
| Name: Mr/ Ms Contact Number: |
| Relationship to you:  |

I give my consent that information regarding my treatment be released to other Prahran East Medical Centre or specialist practitioners as necessary for my care.

Prahran East Medical Centre acknowledges and respects the privacy of individuals. The personal information collected is necessary for us to provide you with the best possible service. By completing this form, Prahran East Medical Centre accepts that you, your parents/guardians (if person is under 18 years of age) have consented for this information to be collected. The intended recipients of this information are Prahran East Medical Centre and its authorized staff. You have the right to access and alter personal information collected in accordance with the Commonwealth Privacy Act, a copy of our privacy policy is available from the practice. **Cancellation policy-allow minimum 4 hours.**

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| **Consent and agreement**I agree to the terms & conditions of registration with Prahran East Medical Centre. For further information refer to our patient information sheet. |
| Name (please print): Date: |
| Signature:  |

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| **\ STAFF USE ONLY** |
| Date entered: Entered by: |

Version 2 June 19