radius
returning the care factor

Form – New Patient

This information is private and confidential and is for use in your clinical file only.

Office Use Only:
Form Completed ☐ Staff Initial _____

PATIENT INFORMATION

Mr. Mrs. Ms. Miss Mast. Dr. Other _____

Patient's First name _____ Known as _____

Last name _____ Date of Birth _____

Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ ATSI

Street address _____

Suburb _____ State _____ Postcode _____

Postal address (if different) _____

Telephone H: _____ W:_____ M: _____

*Please tick - Do you consent to receive SMS appointment reminder: ☐ Yes ☐ No

Email _____

*Please tick - Do you consent to receiving Radius' newsletter to the above email address: ☐ Yes ☐ No

Next of Kin (NOK) Full Name:

Relationship to Patient _____

Contact details H: _____ W: _____ M: _____

Emergency contact Name
Tick if same as NOK ☐ _____

Relationship to Patient _____

Contact details H:_____ W: _____ M: _____

MEDICARE & CONCESSION CARD INFORMATION

Medicare Card No:	Reference No *(next to name)*	Expiry Date:
___ ___ ___ ___ ___ ___ ___ ___ ___ ___		

If patient is under 16 years of age, please provide payer's Medicare details:
Name: Reference No:

Concession Card No:	Concession Card Expiry Date:

Concession Type: (please tick) ☐ Pension Card ☐ Aged ☐ DVA - Gold Card
☐ Health Care Card ☐ Other ☐ DVA – White Card

By becoming a patient of Radius Medical Centre and signing this new patient form, I agree and consent to the following: (please tick)

1. I consent to the use of my personal health information by the Radius Medical Centre and other health care providers involved in my medical treatment and health care with this Centre. ☐
2. I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly in my personal health care or medical treatment. ☐
3. I consent to receive follow up reminders and recalls sent via SMS or mail to my contact details as part of preventative health services offered by this practice when routine investigations are due. ☐
4. I understand that a **minimum of 2 hours' notice to cancel or reschedule** an appointment is required to avoid a fee. ☐
5. I understand that **Schedule 8 scripts will not** be prescribed at my **initial** appointment. ☐

How did you find out about this Medical Centre? (please tick): ☐ Family ☐ Friend ☐ Close to home/work
☐ Website ☐ Online Appointments ☐ Drive/walk past ☐ Other

Patient/Guardian's Signature: _____ Date: _____