This information is needed to provide the best quality care. Your personal health information is kept confidential and secure.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

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:** _____

***Please note (if applicable) -** Parents/Caregivers, if there is a Court Order in place for children from birth to 16 years regarding custodial rights of the child, then a copy of this Order is required for scanning in to the child's medical chart.

Court Order in place ☐ **Yes** ☐ **No** **Admin only**: Reminder Added ☐ **Yes**

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:** **Date Of Birth:**

Concession Card No:	**Concession Card Expiry Date:**

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

CONSENT

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 consent to the sharing of my medical information for research and education purposes provided it is securely de-identified. ☐
5. I understand that a **minimum of 2 hours' notice to cancel or reschedule** an appointment is required to avoid a fee. ☐
6. I understand that **Schedule 8 scripts <u>will not</u>** be prescribed at my **initial** appointment**.** ☐

How did you find out about this Medical Centre? (please tick): ☐ Family/Friend ☐ The Hills Echo Brochure ☐ Close to Home/work ☐ Website ☐ Online Appointments ☐ Drive/walk past ☐ School Newsletter ☐ Other

Patient/Guardian's Signature: _____ **Date:** _____