



# NEW Patient Details Form

## Christies Beach Medical Centre

*Family Health Care Since 1964*  
 100 Beach Road Christies Beach SA 5165  
 Postal Address: PO Box 95 Christies Beach SA 5165  
 Telephone (08) 8384 4444 Facsimile (08) 8384 7374

Family Name: \_\_\_\_\_

Given Name: \_\_\_\_\_

Title:  Mr  Mrs  Ms  Mast  Miss

**Ethnicity Status**

Aboriginal Yes/No

Torres Strait Islander Yes/No

Any other Ethnic Group Yes/No – Please Specify \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Postal Address: \_\_\_\_\_

\_\_\_\_\_ Post Code: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Work/ Mobile: \_\_\_\_\_

Our practice sends SMS appointment reminders

Medicare No.: \_\_\_\_\_ exp \_\_\_\_\_

Veteran Affairs No.: \_\_\_\_\_ exp \_\_\_\_\_

Concession Card;  HCC  Pension  Student  
 \_\_\_\_\_ exp \_\_\_\_\_

Next Of Kin Name: \_\_\_\_\_

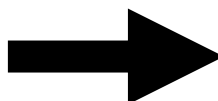
Relationship: \_\_\_\_\_ Ph.: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Ph.: \_\_\_\_\_

Patient/Parent/Guardian Signature: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

**Please read important  
 privacy information and  
 complete authority**



**OFFICE USE ONLY**

File No.: \_\_\_\_\_

First In: \_\_\_\_\_

Staff Member: \_\_\_\_\_

**PLEASE BE AWARE THERE IS A FEE  
 TO PAY FOR A CONSULT IF YOU ARE  
 16 YEARS OLD AND OVER**

If this is a Work Cover claim, please inform the  
 receptionist when returning this form.

**PATIENT PRIVACY  
 INFORMATION**  
*please read carefully*

The Christies Beach Medical Centre (CBMC) requires accurate personal information to be collected to ensure your health needs are met, and the associated administrative processes are conducted in your best interest. In some instances information may be shared with other health care providers to ensure the continuity of your health care (e.g. referrals/ Medicare). All information provided to us is held on our premise, in confidence. You have the right to access your medical records if required.

**Do you authorise a responsible person to call on  
 your behalf to access your medical records (e.g.  
 test results, immunisation data)?**

Yes  No

If so, please print their full name and their  
 relationship to you. Your authorisation does not  
 represent an entitlement for that person to make  
 health care or medical treatment decisions for you.

Name: \_\_\_\_\_

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