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**_____

OFFICE USE ONLY

File No.:_____

First In:_____

Staff Member:_____

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

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: _____