



# 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: \_\_\_\_\_

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

Title:  Mr  Mrs  Ms  Mast  Miss

Birth Sex: \_\_\_\_\_ Gender Identity \_\_\_\_\_

Ethnicity Status

Aboriginal Yes/No      Torres Strait Islander Yes/No

Country of Birth: \_\_\_\_\_

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

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

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

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

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

Email: \_\_\_\_\_

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 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.

Our practice sends SMS appointment reminders and clinical messages      Yes/No

### PATIENT PRIVACY INFORMATION

**please read important privacy information carefully and complete authority**

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). Risks with electronic communication in that the information could be intercepted or read by someone other than the intended recipient. 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: \_\_\_\_\_