Crane Road
Medical Centre

P[Please assist us by completing all details on this New Patient Form and present it to our staff with your Medicare Card and valid Photo ID.p
Please notify us promptly of any changes in your contact details so we can contact you punctually about tests and results.

NEW PATIENT REGISTRATION FORM

1. Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Dr ☐

Family name: ..... **Given name(s):** .....

2. Date of Birth: _____ / _____ / _____ **3. Sex** M ☐ F ☐ Other ☐ Unknown ☐

4. Home Address: **Suburb:** **Postcode:**

5. Postal Address: (tick if same as above) ☐ **Suburb:** **Postcode:**

6. Mobile Ph: **Home Ph:** **Work Ph:**

7. Email:

8. Medicare No: ..... **Ref No:** 1 2 3 4 5 **Expiry:** _____ / _____

9. Concession card: (please tick) Not Applicable ☐ Pension ☐ HCC ☐

Concession card No: ..... **Expiry:** _____ / _____ / _____

10. DVA card No: ..... **Colour:** (please circle) **GOLD / WHITE / ORANGE**

11. Next of Kin details	**12. Emergency Contact details** (☐tick if same as Next of Kin)
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Relationship to you:	**Relationship to you:**

13. Ethnicity: Australian ☐ English ☐ Chinese ☐ Indian ☐ Other: (specify) _____

14. Country of Birth: Australia ☐ UK ☐ China ☐ India ☐ Other: (specify) _____

Are you of Aboriginal or Torres Strait Islander descent? (This information helps with Health Initiatives)

Yes: Aboriginal ☐ Yes: Torres Strait Islander ☐ Yes: Both ☐ No ☐

Patient Consent:

- **I give permission for my medical records and personal health information to be shared between the doctors of the practice for the purpose of my medical care.**
- **I authorise Crane Road Medical Centre to access and upload my health summary to My Health Record.**
- **I agree to allow my doctor to communicate relevant medical information to specialists, hospital staff, pathology labs and other health care providers involved in my medical care.**
- **Our practice provides our patients with preventative care and early case detections reminders e.g. immunisation, skin checks, annual health checks, pap smears etc. As such, I give consent to being contacted with such reminders.**
- **I understand that it is my responsibility to book in appointments to receive results from the requesting Dr or first available GP, within 7 days, unless otherwise specified. I give my consent to being contacted as part of the recall system for the arrival of investigation results. (*Please note, if you say NO, you are solely responsible for contacting the practice to follow up results).**
- **I give my consent to being contacted/reminded of appointment via SMS or call.**
- **I consent to my health record being reviewed as a part of the quality improvement activities at this practice.**
- **I am aware that there is a fee incur for transferring my medical records from Crane Road Medical Centre.**

Cancellation Policy:

A cancellation/no show/reschedule fee will apply for GP consultations including telephone consultations. This fee will not be covered by your insurance company or Medicare. To avoid the fee, you must inform us at least 4 hours PRIOR to your GP appointment (via phone call or email). For other cancellation fees, please visit our website www.craneroadmedicalcentre.com.au or contact reception.

Signature: ..... **Date:** .....

Office use only:	**Entered by:**	**Date:**